DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

August 26, 2025

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

Dear Director Smith:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Monitoring Protocol, which is required by the Special Terms and Conditions (STC), specifically, STC #54 "Monitoring Protocol" of Tennessee's section 1115 demonstration, "TennCare III" (Project Number 11-W-00369/4 and 21-W-00075/9), effective through December 31, 2030. CMS determined that the Monitoring Protocol, which was first submitted on June 7, 2021 and most recently revised on August 25, 2025, meets the requirements set forth in the STCs, and thereby approves the state's Monitoring Protocol.

The Monitoring Protocol is hereby incorporated into the demonstration STCs as Attachment N (see attached). In accordance with STC #97, the approved Monitoring Protocol may now be posted to your state's Medicaid website.

We look forward to our continued partnership on the TennCare III section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
Digitally signed by DANIELLE DALY -S
Date: 2025.08.26 11:41:25 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER LIST

NUMBER: **No. 11-W-00369/4 and 21-W-00075/4**

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 (the 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. Additionally, to enable the state to restrict freedom of choice of provider for the coverage of diapers for children under age 2.

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) eligible for the group at 42 C.F.R. 435.116, and to infants and children under age 19 eligible for the group at 42 C.F.R. 435.118, as described in Section 1902(l)(4)(A) of the Act.

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 66 *(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) of the Act 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) of the Act 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. Parents/Caretaker Relatives

Expenditures for cost of providing coverage to parents/caretaker relatives of dependent children in Tennessee whose incomes exceed the income standard described in the Medicaid State Plan, up to a maximum income level of 100% FPL.

28. Coverage of Diapers for Children under Age 2 in TennCare: Expenditures to provide coverage of a supply of 100 diapers per month per child for children under the age of two enrolled in TennCare.

TITLE XXI COSTS NOT OTHERWISE MATCHABLE

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, through December 31, 2030, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan.

29. **Coverage of Diapers for Children under Age 2 in CoverKids:** Expenditures to provide coverage of a supply of 100 diapers per month per child for children under the age of two enrolled in the Children's Health Insurance Program (CHIP), known in the state as CoverKids.

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** **Section 1902(a)(8) and (10)**

   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. Additionally, to enable the state to restrict freedom of choice of provider for the coverage of diapers for children under the age of two.

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
- 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 (rescinded)
- Attachment Q: DSIP Claiming Protocol (rescinded)
- Attachment R: Maternal Health Enhancements
- Attachment S: CHOICES At Risk Demonstration New Group Enrollment
- Attachment T: Adult Dental Coverage
- Attachment U: Pregnancy Eligibility Group Income Threshold
- Attachment V: CHOICES Benefits

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 five 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(d)(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		

Table 1a TennCare Population Groups		
Description	**Income Limit**	**Provisions of the Act Waived or Made Not Applicable (see Waiver List)**
Caretaker relatives: parents and caretaker relatives with dependent children living in the home	Converted AFDC income standard based on household size *and expenditure authority to extend state plan eligibility up to 100 percent FPL*	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. 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	12 months continued coverage 4 months continued coverage *and expenditure authority for 8 additional months*	1, 6, 7, 8
Pregnant & postpartum women. State utilizes presumptive eligibility for this population.	Income up to and including 250% FPL; no resource test	1, 6, 8
Newborns under age 1.	Income up to and including 195% FPL; no resource test	1, 6, 8
Children 1-5	Income up to and including 142% FPL; no resource test	1, 6, 8
Children 6-18	Income up to and including 133% FPL; no resource test	1, 6, 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, 8
Woman who was eligible while pregnant continues eligibility through the postpartum period		1, 6, 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
“DWB” Disabled widow/widower who lost SSI or state supplement due to early receipt of 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)**
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 *(expenditure authority for 12-month coverage based on 1-month budget period)*	Medically needy spend-down level ($241 for 1, etc.)	1, 2, 4, 6, 7, 8
Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)*	Medically needy spend-down level ($241 for 1, etc.)	1, 2, 4, 6, 7, 8
Title XIX Demonstration Eligible Groups – Carryover		

Table 1a TennCare Population Groups		
Description	**Income Limit**	**Provisions of the Act Waived or Made Not Applicable (see Waiver List)**
CHOICES 1 and 2 Carryover Group: Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria.	Income no more than 300% SSI/FBR; resources $2,000	1, 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, *Rollover Definition]* who are not otherwise eligible for TennCare. See STC 18. *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*.	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)**
Standard Spend Down (SSD): non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)* • aged, blind, or disabled • caretaker relatives 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. *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*.	Medically needy spend-down level ($241 for 1, etc.); resources $2000	1, 2, 4, 6, 7, 8
Title XIX Demonstration Eligible Groups – CHOICES, ECF CHOICES, and Katie Beckett		
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. *(Enrollment Targets for TennCare CHOICES)*.	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)**
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. *(Enrollment Targets for ECF CHOICES)*.	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. *(Enrollment Targets for ECF CHOICES)*.	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. *(Enrollment Targets for ECF CHOICES)*.	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. *Enrollment Targets for ECF CHOICES)*.	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: • have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or • See STC 18 (*Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed)*.	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	• Nursing facility residents who meet the NF LOC in place at the time of enrollment[2]	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	• 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	• "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)	• 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 older[4] 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.

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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 34.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 18[7] 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 18[8] 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;
   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;

[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.

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 receiving1915(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 42 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 2aas 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 55, 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.

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**
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.
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.

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**
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: • 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.
Physicians' services (including medical and surgical services furnished by a dentist)	Outpatient Services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists. Inpatient Services: Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver and bone marrow transplants.	Outpatient services: Covered as medically necessary. Inpatient services: Covered as medically necessary.
Preventive 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**
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.

a. The individual cost neutrality 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.

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 $19,764 per

calendar year, excluding the cost of minor home modifications (as described in Attachment E and Table 2b).

a. 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.

iv. The state may adjust the expenditure limits described in subparagraph iii above as needed in order to reflect provider rate increases over the life of the demonstration. Any adjustments made to the CHOICES 3 or Interim CHOICES 3 expenditure limit will be made publicly available on the state's website. In compliance with STC 6, such adjustments 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.

v. A person enrolled in CHOICES 3 or Interim CHOICES 3 shall not be disenrolled, nor shall currently authorized CHOICES services and supports be reduced, if the sole reason the person's expenditure cap would be exceeded is state-directed rate increases for CHOICES HCBS.

vi. Persons enrolled in CHOICES 2 or CHOICES 3 as of July 12, 2021, are eligible to exceed their individual cost neutrality test or their expenditure cap, as applicable, in order to receive a one-time increase of up to $3,000 across the following services: respite, adult day care, assistive technology, enabling technology, and minor home modifications. A member may elect to receive additional units of one service or multiple services; however, the overall limitation on additional services is $3,000 per person. To qualify for this additional assistance the individual must be enrolled in CHOICES as of July 12, 2021, and living with family members who routinely provide unpaid support and assistance, or if the individual does not live with family members, he must have unpaid family caregivers who routinely provide unpaid support and assistance. The person may not be receiving residential supports. This one-time increase in assistance is available until March 31, 2025, or until any subsequent deadline for states to expend funds associated with the enhanced FMAP for HCBS provided for by the American Rescue Plan Act of 2021, whichever is later.

vii. Definitions for CHOICES benefits are provided in Attachment E of these STCs.

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

Benefit (Definitions provided in Attachment E)	**CHOICES 1**	**CHOICES 2**	**CHOICES 3**[9]
Nursing facility care	X	Short-term only	Short-term only

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

Table 2b: Benefits for Persons Enrolled in the CHOICES Program			
Benefit (Definitions provided in Attachment E)	**CHOICES 1**	**CHOICES 2**	**CHOICES 3[2]**
Community-based residential alternatives (CBRAs)		X	X[10]
Personal care (up to 2580 hours per calendar year)		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
Enabling technology (up to $5,000 per calendar year)[#]		X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X
Employment services and supports (subject to limitations specified in Attachment E)* • 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 • Integrated Employment Path Services		X	X

[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			
Benefit (Definitions provided in Attachment E)	**CHOICES 1**	**CHOICES 2**	**CHOICES 3[2]**
Community transportation (limited to $225 per month for members electing to receive this benefit through consumer direction)		X	X

* Employment services and supports is a covered benefit for CHOICES members until March 31, 2025, or until any subsequent deadline for states to expend funds associated with the enhanced FMAP for HCBS provided for by the American Rescue Plan Act of 2021, whichever is later.

[#] Enabling technology is a covered benefit for CHOICES members until March 31, 2025, or until any subsequent deadline for states to expend funds associated with the enhanced FMAP for HCBS provided for by the American Rescue Plan Act of 2021, whichever is later.

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 $18,420 cap (on benefits), not counting the cost of minor home modifications (as described in Attachment E and Table 2b). The state may grant an exception to the $18,420 cap under the following circumstances:

1. 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.

B. Individuals receiving Essential Supports for Employment and Independent Living benefits will be subject to a $38,820 cap on benefits. The state may grant an exception to the $38,820 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. 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 $62,268 expenditure cap.

2. Individuals with moderate need as determined by the state, in accordance with the published criteria, will be subject to a $95,620 expenditure cap.

3. Individuals with high need as determined by the state, in accordance with the published criteria, will be subject to a $129,048 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. The state may adjust the expenditure limits described in subparagraphs A, B, and C above as needed in order to reflect provider rate increases over the life of the demonstration. Any adjustments made to the expenditure limits for ECF CHOICES Groups 4, 5, or 6 will be made publicly available on the state's website. In compliance with STC 6, such adjustments 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.

6. A person enrolled in ECF CHOICES Groups 4, 5, and 6 shall not be disenrolled, nor shall currently authorized ECF CHOICES be reduced, if the sole reason the person's expenditure cap would be exceeded is state-directed rate increases for ECF CHOICES HCBS.

7. 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.

8. 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.

9. In addition to any other exceptions noted above, individuals receiving Essential Family Supports, Essential Supports for Employment and Independent Living, Comprehensive Supports for Employment and Community Living, and Intensive Behavioral Family Supports are eligible to exceed their expenditure cap in order to receive a one-time increase of up to $3,000 across the following services: respite, assistive technology, adaptive equipment and supplies, enabling technology, and

minor home modifications. A member may elect to receive additional units of one service or multiple services; however, the overall limitation on additional services is $3,000 per person. To qualify for this additional assistance the individual must be enrolled in ECF CHOICES as of July 12, 2021, and living with family members who routinely provide unpaid support and assistance, or if the individual does not live with family members, he must have unpaid family caregivers who routinely provide unpaid support and assistance. The person may not be receiving residential supports. This one-time increase in assistance is available until March 31, 2025, or until any subsequent deadline for states to expend funds associated with the enhanced FMAP for HCBS provided for by the American Rescue Plan Act of 2021, whichever is later.

Table 2c
Benefit Groups for Persons Enrolled in the ECF CHOICES Program

Benefit Groups	Target Population
Essential Family Supports (ECF CHOICES 4)	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. 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. 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
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
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

[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**
	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 34.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	
Community transportation	X	X	X	X	
Independent living skills training (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**
Assistive technology, adaptive equipment and supplies (up to $5,000 per calendar year in combination with Enabling technology)	X	X	X	X	X
Enabling technology (up to $5,000 per calendar year in combination with Assistive technology, adaptive equipment and supplies)	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
− 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

[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—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

l. 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.

n. Children under the age of two enrolled in TennCare may receive a supply of up to 100 diapers per month. This benefit will be administered through TennCare's pharmacy benefit manager, and parents and/or legal guardians of qualifying children may access monthly diaper supplies through participating pharmacies. This benefit is also available to children under the age of two enrolled in CoverKids under Title XXI.

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).

Table 3
Services Excluded from TennCare Standard, Carved Out of TennCare Medicaid Managed Care, and Reported as Base Expenditures Under the State Plan

Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID)
State Plan targeted case management services
Program of All Inclusive Care for the Elderly (PACE) (except for members of the PACE Carryover Group)
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]
Services covered through the state's agreement under Title V of the Social Security Act.

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

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 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 62 (*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. Limits on DSIP claiming. The DSIP will have an established limit in the amount of $1,487,700,000 total computable expenditures, in aggregate, over DYs 3 through 5. The state may claim FFP for up to the annual amounts outlined in Table 4, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period, and the state may claim the

remaining amount in a subsequent demonstration year. Consistent with CMS budget neutrality policy, CMS will rebase expenditure amounts to better reflect actual expenditures after 5 years of the approval period. Beginning in DY 6, DSIP expenditures will be subject to the rebased limit, calculated in accordance with STC 75.

Table 4. Annual Limits in Total Computable Expenditures for DSIP.

	DY3	DY4	DY5
Total Computable Expenditures	$495,900,000	$495,900,000	$495,900,000

e. Implementation Plan: All DSIP (including any subsequent changes in programs) will be subject to the Implementation Plan requirements as outlined in STC 53.

f. Monitoring Protocol: As outlined in STC 54, 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.

g. DSIP Monitoring Reporting: As part of the monitoring reports required under STC 55, the state will report DSIP claims and expenditures to date, in addition to any metrics reporting applicable for DSIP.

h. 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.

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 55 *(Monitoring Reports),* 56 *(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.

ii. The state may permit the use of electronic signature as an additional option to approve the PCSP when a member requests changes to their PCSP prior to their required face-to-face meeting.

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

[17] See footnote 2.

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 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 55 *(Monitoring Reports),* 56 *(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.

g. Other Provisions Related to ECF CHOICES Enrollment and Implementation

i. The state may permit the use of electronic signatures as an additional option to approve the PCSP when a member requests changes to their PCSP prior to their required face-to-face meeting.

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 Group*s.

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 55 *(Monitoring Reports),* 56 *(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 55).

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 and Medicaid Diversion 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.
ii. The state may permit the use of electronic signatures as an additional option to approve the PCSP when a member requests changes to their PCSP prior to their required face-to-face meeting.

VII. COST SHARING/PREMIUMS/PREMIUM ASSISTANCE

36. Cost Sharing. TennCare enrollees are subject to cost sharing as indicated in Table 5. Copay amounts are specified in Table 6.

Table 5
TennCare Demonstration Cost Sharing

Program/Group	Pharmacy Copays	Non-Pharmacy Copays
TennCare Medicaid (state plan enrollees not exempt from cost sharing)	Yes	No
Parents/Caretaker Relatives whose incomes exceed the income standard in the state plan	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 Supports for Employment and Community Living	No	No
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 6 (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 6 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 7 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 7 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 21.b, 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 8 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 8 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
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

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

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 21.a, 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.

IX. GENERAL REPORTING REQUIREMENTS

45. 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.

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

47. 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.

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

49. 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 55.

50. 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.

51. 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 55.

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.

52. 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).

53. 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 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.

54. 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 55 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 55 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.

55. 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, suspension for fraud, and DSIP 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 DSIP 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.

56. 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.

57. 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.

58. 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 45.

59. 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.

60. 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

61. 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 9: 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 1	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	
EG14E Medicaid Diversion	Main			X	

Table 9: Master MEG Chart					
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 Adjustment	Main		X		
UC Pool	Main			X	
DSIP	Main			X	
Access SDP	Report Expenditure				Reporting of state directed payment for eligible inpatient and outpatient hospital services (see STC 69). No savings may be generated by this MEG.

62. 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-00369/4 and 21-W-00075/4). 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 10: 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	Yes	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	Yes	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	Yes	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	Yes	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	Yes	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	Yes	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	Yes	1/8/21	12/31/30
EG8 Med Exp Child	Described in STC 18	None	Follow CMS-64.9 Base Category of	Date of Service	MAP	Yes	1/8/21	12/31/30

Table 10: MEG Detail for Expenditure and Member Month Reporting								
			Service Definitions					
EG9 H-Disabled	Described in STC 17	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Yes	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	Yes	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	Yes	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	Yes	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	Yes	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	Yes	1/8/21	12/31/30
EG16 MEC Additions	Described in expenditure authority 8 and defined as Type 2 in STC 82.b	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Yes	1/8/21	12/31/30
EG17E Less Than MEC Additions	Described in expenditure authority 8 and defined as Type 3 in STC 82.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 10: MEG Detail for Expenditure and Member Month Reporting								
Virtual DSH	Described in STC 66.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	1/821	12/31/30
UC Pool	Described in STC 66.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
Access SDP	Described in STC 69	None	Use Line 18A Medicaid Health Insurance Payments: Managed Care Organizations (MCO)	Date of Payment	MAP	No	7/1/24	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
Diapers Supply for Under 2	Described in expenditure authority 28	None	Use Line 49 Other Care Services	Date of Payment	MAP	No	5/17/24	12/31/30

g. Monitoring Allotment Neutrality

i. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement**. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

A. Tracking Expenditures: In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 and CMS 64 reporting instructions as outlined in section 2115 of the State Medicaid Manual.

B. Use of Waiver Forms: Title XXI demonstration expenditures will be reported on the following separate forms designated for M-CHIP (i.e., Forms 64.21U Waiver and/or CMS-64.21UP Waiver) and S-CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for

which capitation payments were made). The state must submit separate CMS-21 and CMS-64.21U waiver forms for each title XXI demonstration population.

C. Claiming Period: All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the CMS-21 and CMS-64.21U waiver forms, net expenditures related to dates of service during the operation of the demonstration.

ii. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for S-CHIP and CMS-37 for M-CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the S-CHIP population and report demonstration expenditures for the M-CHIP population through Form 64.21U Waiver and/or CMS-64.21UP Waiver. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver and the CMS 64.21U Waiver/CMS-64.21UP Waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

iii. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

iv. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 18 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

v. **Exhaustion of Title XXI Funds for S-CHIP Population.** If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

vi. **Exhaustion of Title XXI Funds for M-CHIP Population**. If the state has exhausted title XXI funds, expenditures for this population as approved within the CHIP state plan, may be claimed as title XIX expenditures, as approved in the Medicaid state plan. The state must notify CMS in writing at least 90 days prior to an expected change in claiming of expenditures for the M-CHIP population. The state shall report demonstration expenditures for these individuals, identified as "M-CHIP," on the Forms CMS 64.9W and/or CMS 64.9P W.

h. **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 d. above) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

ii. All expenditures described in STCs 65.d. *(Extent of Federal Financial Participation for the Demonstration)* and 66 *(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 d. above.

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

Table 11: 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

64. 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.

65. 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 69 *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.

66. 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.

67. 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.

68. Reconciliation of Uncompensated Care Payments. Upon implementation of the distribution methodology described in STC 67 *(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.

69. Access State Directed Payments (SDP). Expenditures for the Access SDP, tracked by CMS as TN_Fee_IPH.OPH4 during the CY 2024 and 2025 rating periods, will be reported in the demonstration's budget neutrality monitoring reports, are not subject to the budget neutrality expenditure limit, and do not generate savings under the budget neutrality agreement. Funds are authorized annually through the state's submission and subsequent CMS approval of an SDP preprint for the purpose of providing a uniform percentage increase for inpatient and outpatient hospital services incorporated into the state's rate certification. Reporting of these amounts within the demonstration budget neutrality reports will be the amount of actual expenditures of increasing hospital services payment, up to the limit authorized by the CMS SDP approval process under 42 CFR 438.6(c). Demonstration reporting of funds authorized for the continuation of the SDP beyond Federal Fiscal Year 2025 is not subject to the amendment provisions in STC 7 *(Amendment Process)* and will be reported in the corresponding demonstration years.

70. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that he 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]

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.

[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 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.

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.

d. Projected PMPMs

	Base Year	Trend Rate	DY 3	DY 4	DY 5
EG1 Disabled	$1,515.31	5.4%	$1,922.17	$2,036.24	$2,146.20
EG2 Over 65	$1,182.01	4.5%	$1,441.28	$1,506.14	$1,573.92
EG3 Children	$253.67	5.5%	$322.89	$340.65	$359.39
EG4 Adults	$442.62	5.3%	$558.60	$588.21	$619.38
EG5 Duals	$890.18	5.5%	$1,142.51	$1,266.44	$1,336.09
EG6E Expan Adult	$242.15	0%	$243.15	$243.15	$243.15
EG7E Expan Child	$2,397.41	5.5%	$2,891.52	$3,050.55	$3,218.33
EG8 Med Exp Child	$572.53	5.5%	$690.53	$728.51	$768.58
EG 9 H-Disabled	$2,017.76	5.4%	$2,425.56	$2,556.54	$2,694.59
EG10 H-Over 65	$1,278.41	4.5%	$1,491.35	$1,558.46	$1,628.59

EG11 H-Duals	$572.53	5.5%	$690.53	$728.51	$768.58
EG13 Katie Beckett Part A	$52,994.41	5.4%	$58,872.34	$62,051.45	$65,402.23
EG15 Katie Beckett Part C	$8,911.86	5.4%	$9,900.33	$10,434.95	$10,998.44
EG16 MEC Additions	--	--	--	--	--

75. 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 PMPM cap to reflect actual spending during the demonstration. The base year starting January 1, 2026 will be updated to reflect actual expenditures/PMPMs 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

76. 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.

77. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 8, Master MEG Chart, and Table 9, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that

would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs. The Access SDP MEG is not considered part of the budget neutrality expenditure limit and does not place the state at risk of exceeding the specified budget neutrality expenditure limit or provide an opportunity to generate savings for the MEG under the demonstration.

78. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once a demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
    a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 78.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration, are outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
    b. **Types of Allowable Changes.** Adjustments will only be made for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
        i. Provider rate increases that are anticipated to further strengthen access to care;
        ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors (such as not aging data correctly) or unintended omission of certain applicable costs of services for individual MEGs;
        iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
        iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
        v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
        vi. High cost innovative medical treatments that states are required to cover; or,
        vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

79. 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 one of more components: per capita components, which are calculated as a projected without waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. 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.

80. 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."

81. 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.

82. 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 12: Main Budget Neutrality Test

MEG	PC or Agg	WOW Only, WW Only, or Both	DY 3	DY 4	DY 5
EG1 Disabled	**PC**	Both	$1,922.17	$2,036.24	$2,146.20
EG2 Over 65	**PC**	Both	$1,441.28	$1,506.14	$1,573.92
EG3 Children	**PC**	Both	$322.89	$340.65	$359.39
EG4 Adults	**PC**	Both	$558.60	$588.21	$619.38
EG5 Duals	**PC**	Both	$1,142.51	$1,266.44	$1,336.09
Virtual DSH Pool	**Agg**	WW only	Calculated in accordance with STC 67.		
EG12E Carryover	**Agg**	WW only	The state must have savings to offset these expenditures.		
EG14E Medicaid Diversion	**Agg**	WW only	The state must have savings to offset these expenditures.		
EG17E Less than MEC additions	**Agg**	WW only	The state must have savings to offset these expenditures.		
UC Pool	**Agg**	WW only	Calculated in accordance with STC 67.		

DSIP	**Agg**	WW only	$495,900,000	$495,900,000	$495,900,000
GME	**Agg**	WW only	$50,000,000	$50,000,000	$50,000,000
Diapers Supply for Under 2	**Agg**	WW only	--	$27,532,278	$27,532,278

83. 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 13: Hypothetical Budget Neutrality Test					
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**DY 3**	**DY 4**	**DY 5**
EG6E Expan Adult	PC	Both	$243.15	$243.15	$243.15
EG7E Expan Child	PC	Both	$2,891.52	$3,050.55	$3,218.33
EG8 Med Exp Child	PC	Both	$690.53	$728.51	$768.58
EG9 H-Disabled	PC	Both	$2,425.56	$2,556.54	$2,694.59
EG10 H-Over 65	PC	Both	$1,491.35	$1,558.46	$1,628.59
EG11 H-Duals	PC	Both	$690.53	$728.51	$768.58
EG13 Katie Beckett Part A	PC	Both	$58,872.34	$62,051.45	$65,402.23
EG15 Katie Beckett Part C	PC	Both	$9,900.33	$10,434.95	$10,998.44
EG 16 MEC Additions	PC	Both	--	--	--

84. DSH Adjustment. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and was calculated in accordance with current law. Table 14 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 14	
	DSH Adjustment (total computable)
TennCare III DY 1	$508,936,029 (this amount is contingent on close out reconciled expenditures in TennCare II DY19 not exceeding the 6 month amount of this figure being claimed for the period end on December 31, 2020.

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

85. 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.

86. 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 PMPM cap to reflect actual spending during the demonstration. The base year starting January 1, 2026 will be updated to reflect actual expenditures/PMPMs 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. The Main Budget Neutrality Test for this demonstration period may incorporate carryforward savings, that is, net savings from the 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. 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.

c. If at the end of the demonstration approval period the Main Budget Neutrality Test 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.

Main Budget Neutrality Test

Table 15: 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

87. 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 45.

88. 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.

89. 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 93 and 94.

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.

90. 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 Design*s*, 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.

91. 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, as well as improved health outcomes and beneficiary satisfaction for CHOICES and ECF CHOICES programs. Evaluation of the HCBS enhancement components of the demonstration should examine impacts on access to and utilization of these services. Finally, the state must develop hypotheses and research questions to evaluate the effectiveness of the coverage of diapers for children under the age of 2. Specifically, an evaluation is expected to include an assessment of the effects of the initiative on infant health care utilization and appropriate measures of infant health outcomes (e.g., rates of infant urinary tract infection and diaper dermatitis).

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.

92. **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.

93. **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.

94. 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.

95. 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.

96. 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.

97. 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.

98. 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.

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.

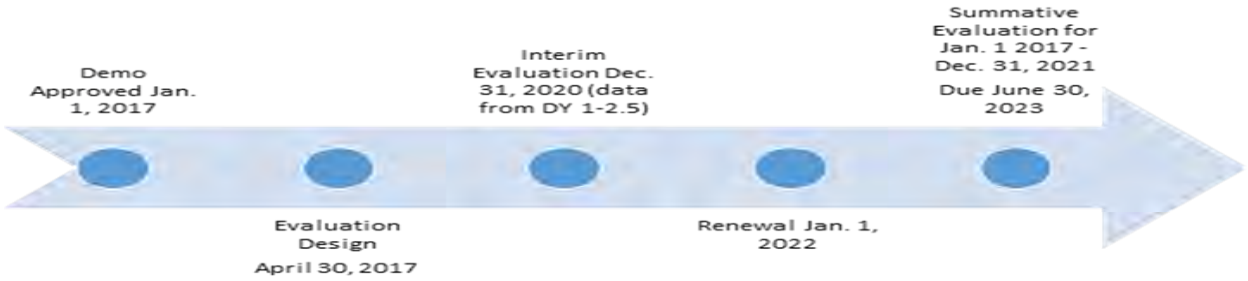
The format for the Evaluation Design is as follows:

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 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.
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/hciatwoaimsdrvrs.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.
    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.

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.

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. 3Timeline 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.

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.

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.



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.

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?
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

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.

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.

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

    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:

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.

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:

a. For which an individual is compensated at or above the state's minimum wage and is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals without disabilities, not including supervisory personnel or individuals providing services to the employee with a disability, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; or in the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities, and who are self- employed in similar occupations or on similar tasks and who have similar training, experience, and skills; and is eligible for the level of benefits provided to other employees; and is engaged, preferably, in full-time work; and
b. Is at a location that is typically found in the community; to be typically found in the community, an employment location should be found in the competitive labor market and not formed for the specific purpose of employing individuals with disabilities; and
c. Where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and
d. That, as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions; and
e. That is not paid employment or training in a business enterprise owned or operated by a provider of the individual's employment services.

Individualized Integrated Self-Employment: Sustained paid self-employment that is homebased 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 startup period.

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.

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
- 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 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 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 transportation shall be limited to no more than $225 per month for persons electing to receive this service through Consumer Direction.

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.

Enabling Technology.
Enabling Technology is equipment and/or methodologies that, alone or in combination with associated technologies, provides the means to support the individual's increased independence in their homes, communities, and workplaces. 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 that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation.

Enabling Technology includes remote support technology systems in which remote support staff and/or coaches and/or natural supports can interact, coordinate supports, or actively respond to needs in person when needed. Remote support systems are real time support systems which often include two-way communication.

Enabling technology is an available support option for all aspects and places of participants' lives.

- These systems use wireless technology, and/or phone lines, to link an individual's home to a person off-site to provide up to 24/7 support.
- These systems include the use of remote sensor technology to send "real time" data remote staff or family who are immediately available to assess the situation and provide assistance according to a Person-Centered Support Plan (PCSP).

Examples of enabling technologies typically used in peoples' homes include:
- Motion sensors
- Smoke and carbon monoxide alarms

- Bed and/or chair sensors
- Live or on demand audio and/or video technologies
- Pressure sensors
- Stove guards
- Live web-based remote supports
- Automated medication dispenser systems
- Mobile software applications using digital pictures, audio and video to guide, teach, or remind
- GPS guidance devices
- Wearable and virtual technologies
- Software to operate devices for environmental control or to communicate with other smart devices, paid or natural supports at home, at work, or any other place of personal import.

Enabling Technology excludes coverage of connectivity for internet or telephone service for use of this equipment, to the extent coverage of such services is prohibited by CMS

EMPLOYMENT SERVICES AND SUPPORTS

Supported Employment—Individual Employment Support

These services are provided on an individual basis 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 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).

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 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 sixty (60) calendar days from the date of service initiation. This service is not appropriate

for CHOICES 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.

Self-Employment Exploration to include but not limited to: Initial meeting with job coach or job developer to discuss self-employment goals, collecting information to assist the person in making an informed choice on the pursuit of self-employment, and feasibility study and consultation with local advisory agencies. This may consist of virtual or in-person meetings with job developer and advisory agencies with the goal of informing the person on self-employment. At the conclusion of Exploration, the individual will choose whether to continue pursuing self-employment. Additionally, the job developer will work to identify supports needed, discuss fading of paid job supports, and the expectations of job developer and job seeker. Completion and approval of SE Exploration template required for completion. Benefits counseling is mandatory during this phase through Vocational Rehabilitation or CHOICES.

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 for Exploration for Individualized Integrated Employment or Exploration for Self-Employment (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:

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 alleviates 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, CHOICES, 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) or certified Work Incentive Practitioner (WIP-C). 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.), CHOICES 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.

c. PRN (pro re nata/as needed) 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 CHOICES, the person will be assisted by his or her Care 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.

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.

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 for Job Development Plan and is limited to ninety (90) calendar days from the date of service initiation for Self-Employment Plan. 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. For Self-Employment Plan, the following additional items are required, and the service is expected to take around 50 hours to complete:

- Attend one of the small business orientation classes if not completed during Self-Employment (SE) Exploration – options listed under SE Exploration.
- Complete Feasibility Study with business mentor.
- Completion of Self-Employment Plan Template and business plan. This should promote further questions for start-up consultant, person supported, etc.
- Contacting sources of start-up capital, beginning process of obtainment. (PASS, VR, Loans, Crowdsourcing).
- Identifying licensure needed, inspections, liability insurance, etc. – and begin process of licensure. Reference the following site to determine if licensure is required: Registration and Licensing (tn.gov)
- Identifying total cost and how to obtain all resources and licensure needed. Confirm funding.
- Final consultation with job developer and the advisor to review Self-Employment Plan and business plan and give further recommendations prior to start-up.
- Benefits counseling consultation – if individual did not elect to pursue SE Exploration, ensure benefits counseling is received during this phase
- A final template verifying not only Self-Employment Plan, but resources, funding, licensure needed, how it was obtained, and next steps. Submission and approval of the template is required and will need approval at the completion of this phase. The expected outcome of this phase is to obtain all needed goods, licensure, services, and assistive/enabling technology necessary for a person to start their business. A final meeting with person supported, job developer, and advisor is required before completion. The business plan and completed SE Plan Template need to be submitted to Employment Specialist in order to complete service.

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:

- **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 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 be 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. First payment for Self-Employment Start-Up will be following ten (10) business days "open." Self-employment

business "open" means the first day of offering the sale of goods or services. Proof of licensure is needed for self-employment outcome, indicating active self-employment. Outcome payment amounts for Job Development Start-Up are tiered based upon the assessed level of challenge anticipated to achieve the intended outcome of this service for the individual being served. The outcome payment amounts for Self-Employment Start-Up are not tiered. Outcome payments for both Start-Up services 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 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 (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.

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 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.

10. 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.
- 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.

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.

Supported Employment – Individual Employment Supports Service Limitations:

- 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.

EMPLOYMENT & DAY SUPPORTS

Mobile Technologies to teach safe travel skills and guide people during community travel to work or other places important in their lives, by walking or using public transportation.

Enabling technology options include:

- Mobile software applications using digital pictures, audio and video to guide, teach, or remind
- GPS guidance devices
- Wearable and virtual technologies
- Software to support communication with people along participants' routes or destinations.

Rideshare/ Community Transportation Pre-authorization of (up to) a $500 coupon code or pass per month based on person's travel plans or needs, (work, school, shopping, movies, etc.).

This benefit can also be used to pay a car pooler back for gas, for bus fare, a taxi service, etc.

PRE-EMPLOYMENT: EXPLORATION

Digital Career Exploration

Self-directed or guided exploration of jobs and job tasks via a computer environment or a smart device's software application using digital pictures, audio and video to enable participants and job developers to identify jobs that match the individual's job interests.

Digitals tools for interest/skill exploration, member background information, scenario activities to identify skill set, learning styles, support needs.

Virtual Reality

Jobseekers can experience first-hand the pros and cons of various occupations by seeing, hearing and feeling what they are actually like.

PRE-EMPLOYMENT: DISCOVERY/JOB DEVELOPMENT

Online tools for job hunting such as job boards, job interview tasks & tips, conditions for success, job/skill evaluations, scenario activities.

REMOTE COACHING

Job Coaching includes supports provided to the person and their supervisor or co-workers, either remotely (via technology) or face-to-face.

A device that otherwise meets the requirement for two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system.

Mobile technologies, video modeling, task prompting software applications, GPS-based applications; wearable technologies; virtual, augmented, mixed reality systems.

FADING

A mobile technology that offers long-term support on the job, in lieu of paid support, that may encompass job tasks, social behavior, or communication.

The use of enabling and/ or mobile technologies to support fading may cover a wide array of person-centered needs that include attendance, punctuality, self-managing breaks, interpersonal skills, appearance, communication, sequencing job tasks, etc.

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

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

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

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

Minor home modifications. Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

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

Personal care. Help or hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs 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, personal care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal 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.

Personal care services are covered with a limit of 2,580 hours per calendar year per member. Personal care services are not covered when an enrollee is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving any of the following HCBS: Adult Day Care, CBRA Services (including Companion Care), or Short-Term NF Care.

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.

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.

The state will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the state can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The state will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, state and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the state specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the state specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS.

Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, certain aspects of which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

Preamble

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Public Hospital Costs Sub-Pool of the Virtual DSH Fund (see STC 66.a and the distribution methodology described in STC 67). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the state as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the state continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under Section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs as eligible under title XIX or XXI (or under Section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non- governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

I. Cost Computation

A. TN CPE 1115 – Medicaid Fee-For-Service

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

B. TN CPE 1115 – Medicaid Managed Care

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the

payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to

determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

II. Payments and Recoveries

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds) including any related patient co-payments, or payments from other non-state payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series.

Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the state's fiscal year, the state will proportionally allocate to the state plan rate year the costs of two cost report periods encompassing the state Plan payment year. To do so, the state will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the state plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the state plan rate year ending 9/30/2007, and one-fourth of the state plan rate year ending 9/30/2008. To fulfill reconciliation requirements for state plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the state plan rate year.) The state will ensure that the total costs claimed in a state plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

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:

A. For which an individual is compensated at or above the state's minimum wage and is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals without disabilities, not including supervisory personnel or individuals providing services to the employee with a disability, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; or in the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities, and who are self-employed in similar occupations or on similar tasks and who have similar training, experience, and skills; and is eligible for the level of benefits provided to other employees; and is engaged, preferably, in full-time work; and
B. Is at a location that is typically found in the community; to be typically found in the community, an employment location should be found in the competitive labor market and not formed for the specific purpose of employing individuals with disabilities; and
C. Where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and
D. That, as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions; and
E. That is not paid employment or training in a business enterprise owned or operated by a provider of the individual's employment services.

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.

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 and Supports

Supported Employment—Individual Employment Support

These services are provided on an individual basis[20] 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

[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.

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 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 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:

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 CHOICES, 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) or certified Work Incentive Practitioner (WIP-C). 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 CHOICES 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.

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.

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.

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:

- **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 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 be 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 has completed two calendar weeks of individualized integrated employment or self-employment. Payment for selfemployment will be following ten (10) business days "open." Self-employment business "open" means the first day of offering the sale of goods or services. Proof of licensure is needed for self-employment outcome, indicating active self-employment. Outcome payment amounts for Job Development Start-Up are tiered based upon the assessed level of challenge anticipated to achieve the intended outcome of this service for the individual being served. The outcome payment amounts for Self-Employment Start-Up are not tiered. Outcome payments for both Start-Up services 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 selfemployment 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 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 (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.

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:

4. 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.

5. 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.

6. 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 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:

c. 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.

d. 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:

- 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 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 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.

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.

- 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 opportunities[21] as approved by TennCare[22]. 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.

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

[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.

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:

- 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:

- 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.

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.

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.

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 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 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;
- 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 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;
- 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 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, 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]"

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,

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

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:
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.

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-centered[24] 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 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 Intellectual and Developmental

[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.

[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.

Disabilities for the delivery of HCBS for individuals with I/DD.[26] Behavioral health assessment, planning and treatment components of the benefit are provided by a Masters level licensed clinician and tailored to the needs of children with I/DD. Supportive service components (i.e.,"Intensive Behavioral Supportive Home Care") are provided by Behavior Support Specialists[27] 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 management) plan in all aspects of daily life[28] 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 build and maintain strong partnerships with a psychiatrist or other appropriately licensed psychiatric professional through strong coordination of care and 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-term[29] intensive 24/7 community-based

[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 training, experience, and structured clinical supervision while 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.

[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 some instances, IBCTSS may be utilized to support longer term implementation of a plan to fade from high

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 defined by the ISCT and subsequent phases to approve or extend phases, or return to phases as appropriate) behavioral-focused residential planning, stabilization and treatment program that addresses the mental health and stabilization needs of: 1) adults[30] 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 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 Intellectual and Developmental Disabilities for the delivery of residential services for individuals with I/DD. Behavioral health assessment, planning and treatment components of the benefit are provided by a Masters level licensed clinician and tailored to the needs of individuals with I/DD. Residential service components are provided by Behavior Support Specialists[31] with training and expertise in serving individuals with I/DD who have a severe behavioral and/or psychiatric condition.

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 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.

[31] Behavior Support Specialists are expected to have substantial training, experience, and structural clinical supervision while 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.

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] work[33] 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 build and maintain a strong partnership with a psychiatrist or other appropriately licensed psychiatric professional through strong coordination of care and to facilitate timely access to psychiatric care, as needed.

Enabling Technology
As defined in Attachment E.

[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.

Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Evaluation Design (Revised)

Project No. 11-W-00369/4

Updated November 19, 2024

Division of TennCare

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A. General Background Information

Section 1115 of the Social Security Act allows states to design and implement innovative Medicaid program strategies to enhance cost-efficiency and quality of care for Medicaid-eligible populations. The Secretary of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) have the authority to approve demonstration projects that grant states certain program flexibilities. States can use Section 1115 demonstrations to employ these flexibilities while continuing to meet minimum care standards set by federal law.

On January 8, 2021, CMS approved Tennessee's Section 1115 demonstration project, TennCare III (Project Number 11-W-00369/4). The TennCare III approval period spans from January 8, 2021 to December 31, 2030.

As part of the demonstration's Special Terms and Conditions (STCs), CMS requires an evaluation of the program's ability to meet its intended goals. This Evaluation Design addresses CMS general guidance on Section 1115 demonstration evaluations as well as the Tennessee-specific requirements outlined in the STCs. The Evaluation Design will guide subsequent TennCare III Evaluation Reports.

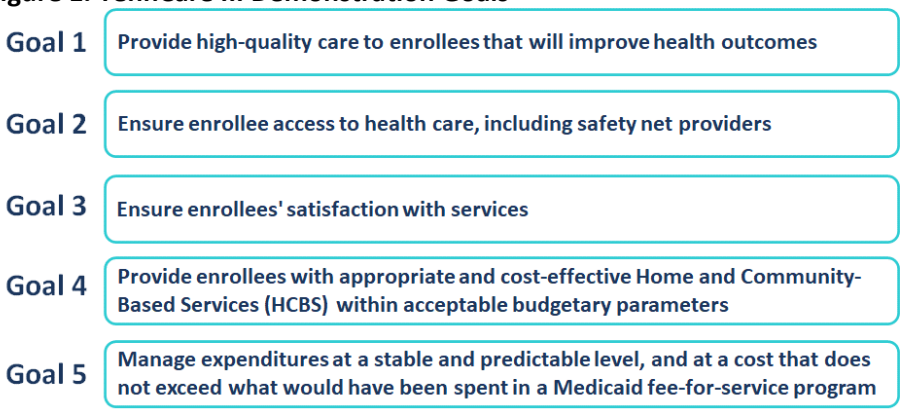
This Evaluation Design will guide the federally-required independent evaluation of TennCare III, and is organized as follows:

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

1. Demonstration Goals

Over the course of the TennCare III demonstration period, TennCare seeks to achieve five primary demonstration goals, which inform the evaluation of TennCare III. Each goal, outlined in **Figure 1**, aligns with Section 1115(a) and Medicaid program objectives, including improving health outcomes, quality of care, and access to care for Medicaid beneficiaries.[1]

Figure 1. TennCare III Demonstration Goals



These goals have served as the foundation of the TennCare program since its inception.

[1] CMS, About Section 1115 Demonstrations, https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

2. Description of the Demonstration and Implementation History

TennCare, which began in January of 1994, is one of the longest-running Medicaid demonstrations in the nation. The original TennCare demonstration created the first Medicaid managed care program in Tennessee. The original TennCare demonstration employed managed care organizations (MCOs) and extended coverage to many previously uninsured individuals.

TennCare II, which revised the existing TennCare demonstration and divided program populations into "TennCare Medicaid" (for enrollees who are Medicaid-eligible under Tennessee's Title XIX State Plan) and "TennCare Standard" (for enrollees who are Medicaid-eligible through the demonstration's expenditure authorities), was first implemented in July 2002. Over time, the TennCare demonstration has been revised to integrate more components of the Medicaid program into managed care.

The current TennCare III demonstration, which began on January 8, 2021, subsumes TennCare II and continues many of the existing TennCare II authorities, as well as new flexibilities.

This Evaluation Design covers continuing and new policies.

Continuing Policies under TennCare III

The majority of TennCare III demonstration policies pre-date its approval and are a continuation of TennCare II components. The managed care system, CHOICES program, Employment and Community First (ECF) CHOICES program, Katie Beckett/Medicaid Diversion program, and retroactive eligibility waiver were all implemented in prior demonstration periods and will continue under TennCare III. This subsection further describes select key, continuing policies continuing under TennCare III.

CHOICES Program

The CHOICES managed long-term services and supports (MLTSS) program was first implemented in 2010 to provide older adults and adults with physical disabilities an integrated benefits package of long-term services and supports (LTSS), which includes both home and community-based services (HCBS) and nursing facility (NF) services. Under TennCare III, the State will continue the CHOICES program for eligible individuals and, in doing so, maintain or expand access to HCBS for TennCare enrollees who are elderly or physically disabled.

ECF CHOICES Program

The ECF CHOICES program, implemented in 2016, expanded the use of managed care to provide HCBS to individuals who have an intellectual or developmental disability (I/DD). This program provides an integrated HCBS benefits package that includes integrated employment supports. The ECF CHOICES program will continue under TennCare III and the State will prioritize reducing the ECF CHOICES waitlist, increasing enrollee independence, and continuing to achieve individual employment goals for the I/DD population.

Katie Beckett/Medicaid Diversion Program

In November 2020, the State began implementing a Katie Beckett/Medicaid Diversion program for children with disabilities or complex needs whose parents' income or assets render the child ineligible for traditional Medicaid coverage. The State's program consists of two parts: Part A and Part B.

The Katie Beckett component of the program (Part A) is targeted to children with the most severe needs, and provides a pathway to traditional Medicaid coverage, supplemented by a package of essential supportive

services. The Medicaid Diversion component of the program (Part B) provides a targeted package of services and supports designed to prevent or delay the need for traditional Medicaid supports.

Retroactive Eligibility Waiver

TennCare's retroactive eligibility waiver enables the State not to extend eligibility to an enrollee prior to the date that an application for assistance is made. This waiver was first authorized by CMS in 1994 and will continue under TennCare III; however, the waiver will no longer apply to certain pregnant women and children who enroll in TennCare. Under TennCare III, these pregnant women and children will receive retroactive coverage for medical costs incurred up to three months before the month of application.

Uncompensated Care Pools

TennCare authorizes the State to make uncompensated care payments to hospitals and other safety net providers. The demonstration includes two funds that provide from which uncompensated care payments may be made, the "Virtual DSH" fund and the Uncompensated Care Fund for Charity Care. TennCare III gives the State certain flexibility to adjust the distribution methodology for uncompensated care payments.

New Policies under TennCare III

Multiple policies and flexibilities were approved by CMS as part of the TennCare III demonstration. As a means of advancing the programmatic goals outlined in Section A.1, CMS has authorized the following:

- **Designated State Investment Programs (DSIPs).** Provides Tennessee with an opportunity to obtain shared savings.
- **Fraud Penalties.** Allows TennCare to temporarily suspend Medicaid eligibility for enrollees convicted of Medicaid fraud.
- **Integration of Services for Individuals with Intellectual Disabilities.** Integrates 1915(c) HCBS waiver services for individuals with intellectual disabilities and ICF/IID services into the larger managed care program.[2]

Designated State Investment Programs (DSIPs)

The TennCare III demonstration gives Tennessee the opportunity to share in savings each year if the State underspends the budget neutrality cap. The shared savings component of the demonstration creates potential opportunities for the State to make key investments in the Medicaid program and the health of Medicaid beneficiaries.

Fraud Penalties

TennCare has the authority to suspend, for up to 12 months, Medicaid eligibility for individuals who have been convicted of Medicaid fraud.

Amendment 1: Integration of Services for Individuals with Intellectual Disabilities

After the approval of TennCare III, the State submitted a demonstration amendment, Amendment 1, to integrate services for members with intellectual disabilities into the managed care program authorized under the demonstration. The State plans to integrate all Medicaid services for individuals with intellectual disabilities into the TennCare managed care program. Specific services to be integrated include Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID) and the State's remaining Section 1915(c) HCBS waiver services. Affected HCBS will continue to be authorized under Section 1915(c) waivers,

[2] Pending CMS approval of TennCare III, Amendment I.

but the associated services will be added to the package of managed care benefits administered by the MCOs. Pending CMS approval of this amendment, the independent evaluator will examine the related research questions included in this Evaluation Design.

Amendment 2: Extending Coverage to Children Adopted from State Custody

After the approval of TennCare III, the State submitted a demonstration amendment, Amendment 2, to extend its coverage to children adopted from state custody who do not currently qualify for TennCare. This group of children will receive services through TennCare's existing managed care program and will receive the same benefits as all other children enrolled in TennCare. Pending CMS approval of this amendment, the independent evaluator will examine the related research question included in this Evaluation Design.

Amendment 3: Increase HCBS Expenditure Caps

After the approval of TennCare III, the State submitted a demonstration amendment, Amendment 3, to increase HCBS expenditure caps for certain CHOICES and ECF CHOICES members and to add Enabling Technology as a covered service in CHOICES and ECF CHOICES. These changes were initially implemented via an emergency 1115 authority during the COVID-19 public health emergency, and Amendment 3 codified these polices within the demonstration on a permanent basis. These changes are expected to contribute to key goals of the TennCare demonstration reflected in the evaluation design, specifically Goal 4 around providing enrollees with appropriate and cost-effective HCBS.

Amendment 4: Transition to Per Member Per Month (PMPM) Budget Neutrality Cap and Removal of Closed Drug Formulary

After the approval of TennCare III, the State submitted a demonstration amendment, Amendment 4, to transition its budget neutrality framework from an aggregate cap to a PMPM basis and remove the authority to implement a closed drug formulary. TennCare adjusted this Evaluation Design to reflect these changes and the independent evaluator will examine the related research questions included in this Evaluation Design.

Amendment 5: Supporting Strong Families

After the approval of TennCare III, the State submitted a demonstration amendment, Amendment 5, to make several updates, including expand eligibility for parents and caretaker relatives of dependent children, provide a new benefit to cover a supply of diapers for infants and young children enrolled in TennCare and the Children's Health Insurance Program, and enhance HCBS available to individuals with disabilities under the demonstration, with particular emphasis on employment supports. The independent evaluator will examine the related research questions included in this Evaluation Design.

Amendment 6: Extending Coverage to Working Individuals with Disabilities

After the approval of TennCare III, the State submitted a demonstration amendment, Amendment 6, to expand TennCare coverage to additional working individuals with disabilities. Individuals who qualify will receive the full TennCare benefits package through the managed care program as provided to all other persons enrolled in TennCare and may receive HCBS to the extent they are eligible. These changes are expected to contribute to key goals of the TennCare demonstration reflected in the evaluation design, specifically Goal 4 around providing enrollees with appropriate and cost-effective HCBS.

Other Components of TennCare III

In addition to the continuing and new demonstration policies, other notable aspects of TennCare III include the following.

Administrative Flexibilities

TennCare has the authority to both extend TennCare eligibility and expand benefit packages without prior CMS approval. Any coverage or benefit changes made without prior CMS approval must be additive in nature. TennCare can use this flexibility to make meaningful decisions about program management and quickly respond to changes in the enrollee population or emerging public health issues. Since January 2021, TennCare has brought forth a number of program improvements through administrative flexibilities, such as expanding dental benefit for all adults, expanding postpartum coverage from 60 days to 12 months following the end of pregnancy, and adding new employment support services to CHOICES. The independent evaluator will examine the related research questions in this design.

3. Population Groups Impacted by the Demonstration

The independent evaluator will evaluate whether TennCare III has the intended effect on the target populations, further described in Section C.4. The Evaluation will encompass all populations described in the STCs.

B. Evaluation Questions and Hypotheses

Section B outlines the hypotheses and research questions (RQs) related to each of the five demonstration goals described in Section A. In addition, this Section includes the TennCare III Driver Diagram and related Logic Models.

1. Goal 1: Provide high-quality care to enrollees that will improve health outcomes

The Evaluation will test four hypotheses to evaluate whether TennCare III policies have maintained or improved health outcomes. **Figure 2** outlines the hypotheses and RQs that relate to Goal 1.

Note: Because the majority of TennCare III policies are continued from prior iterations of the TennCare demonstration, it is intended for the independent evaluator to isolate the effects that TennCare III has on these efforts, where feasible.

Figure 2. Goal 1 – Hypotheses and Research Questions

Hypotheses	Research Questions
Hypothesis 1.1 – Following implementation of the TennCare III demonstration, quality of care and health outcomes for TennCare enrollees will maintain or improve.	**Primary RQ 1.1.a:** Has the implementation of TennCare III maintained or improved physical health outcomes for TennCare enrollees? **Primary RQ 1.1.b:** Has the implementation of TennCare III maintained or increased the utilization rates of preventive or wellness services for TennCare enrollees? **Primary RQ 1.1.c:** Has the implementation of TennCare III maintained or increased the utilization rates of EPSDT services for TennCare enrollees? **Primary RQ 1.1.d:** Has the implementation of TennCare III maintained or improved the management of behavioral health (BH) conditions for TennCare enrollees?
Hypothesis 1.2 – Following implementation of the TennCare III demonstration, opioid	**Primary RQ 1.2.a:** Has the implementation of TennCare III maintained or decreased opioid misuse among TennCare enrollees (i.e., first-time, acute, and chronic opioid users)? **Primary RQ 1.2.b:** Has the implementation of TennCare III maintained or decreased the

Hypotheses	Research Questions
misuse will maintain or decrease among TennCare enrollees, access to medication-assisted treatment (MAT) will maintain or increase, and health outcomes associated with opioid misuse will maintain or improve.	number of Neonatal Abstinence Syndrome live births? **Primary RQ 1.2.c:** Has the implementation of TennCare III maintained or improved the rate of opioid use disorder (OUD) treatment for TennCare enrollees? **Primary RQ 1.2.d:** Has the implementation of TennCare III maintained or improved access to MAT?
Hypothesis 1.3 – Following implementation of the TennCare III demonstration, quality outcomes and quality of life for TennCare CHOICES enrollees and individuals with I/DD will maintain or improve.	**Primary RQ 1.3.a:** Has the implementation of TennCare III maintained or improved quality outcomes for CHOICES enrollees? **Primary RQ 1.3.b:** Has the implementation of TennCare III maintained or improved quality of life for CHOICES enrollees? **Primary RQ 1.3.c:** Has the implementation of TennCare III maintained or improved quality outcomes for individuals with I/DD? **Primary RQ 1.3.d:** Has the implementation of TennCare III maintained or improved quality of life for individuals with I/DD?
Hypothesis 1.4 – Following enrollment in the Katie Beckett program, quality of life, family outcomes, and health outcomes will maintain or improve for children eligible for Parts A and B of the Katie Beckett program.	**Primary RQ 1.4.a:** Has enrollment in the Katie Beckett program maintained or improved quality of life for eligible children? **Primary RQ 1.4.b:** Has enrollment in the Katie Beckett program maintained or improved health and family outcomes for eligible children?
Hypothesis 1.5 – Following implementation of the TennCare III demonstration, costs associated with treating conditions related to diapers for children under age 2 will decrease, as will the rates of those conditions.	**Primary RQ 1.5.a:** Has the implementation of TennCare IIII decreased the costs associated with the treatment of diaper rash/diaper dermatitis, as well as the rates of those conditions, in children under age 2? **Primary RQ 1.5.b:** Has the implementation of TennCare IIII decreased the costs associated with the treatment of urinary tract infections (UTIs), as well as the rates of UTIs, in children under age 2?

2. Goal 2: Ensure enrollee access to health care, including safety net providers

The Evaluation will test ten hypotheses to evaluate whether TennCare III policies have impacted enrollee access to health care, including safety net providers. **Figure 3** outlines the hypotheses and RQs that relate to Goal 2.

Note: Because the majority of TennCare III policies are continued from prior iterations of the TennCare

demonstration, it is intended for the independent evaluator to isolate the effects that TennCare III has on these efforts, where feasible.

Figure 3. Goal 2 – Hypotheses and Research Questions

Hypotheses	Research Questions
Hypothesis 2.1 – Following implementation of the TennCare III demonstration, enrollee utilization of services will maintain or improve.	**Primary RQ 2.1.a:** Has the implementation of TennCare III maintained or improved enrollee utilization of services?[3] • Primary care visits • Inpatient visits • BH visits • Prescription drugs **Subsidiary RQ 2.1.a.i:** Has the implementation of TennCare III maintained or improved utilization of primary care? **Subsidiary RQ 2.1.a.ii:** Has the implementation of TennCare III maintained or improved utilization of inpatient care? **Subsidiary RQ 2.1.a.iii:** Has the implementation of TennCare III maintained or improved utilization of BH treatment? **Subsidiary RQ 2.1.a.iv:** Has the implementation of TennCare III maintained or improved utilization of outpatient prescription drugs?
Hypothesis 2.2 – Following implementation of the TennCare III demonstration, access to comprehensive primary care will maintain or increase.	**Primary RQ 2.2.a:** Has the implementation of TennCare III maintained or increased the number and proportion of TennCare enrollees cared for through the PCMH model?
Hypothesis 2.3 – Following implementation of the TennCare III demonstration, member engagement in prenatal and postpartum care will maintain or increase.	**Primary RQ 2.3.a:** Has the implementation of TennCare III maintained or increased member engagement in prenatal care? **Primary RQ 2.3.b:** Has the implementation of TennCare III maintained or increased member engagement in postpartum care? **Primary RQ 2.3.b.i:** Has the implementation of TennCare III increased the months of continuous coverage for postpartum women? **Primary RQ 2.3.b.ii:** Has the implementation of TennCare III increased the use of lactation consultation services among postpartum women?
Hypothesis 2.4 – Following implementation of the	**Primary RQ 2.4.a:** What strategies did the MCOs implement to address non-medical needs affecting enrollees' health?

[3] The independent evaluator will examine whether observed changes in service utilization measures suggest that the volume and mix of services utilized is shifting in the direction of lower cost types of care, when clinically appropriate (e.g., if increased primary care visits are observed, if there is an association between primary care visit rates and emergency department visit and inpatient visit rates). The independent evaluator will interpret the service utilization measures in the context of other measures in the Evaluation (e.g., health outcome measures).

Hypotheses	Research Questions
TennCare III demonstration, MCOs will encourage and/or facilitate the identification of non-medical needs affecting enrollees' health and the referral of enrollees to resources.	**Primary RQ 2.4.b:** Has the percentage of enrollees screened for non-medical needs affecting enrollees' health increased following the implementation of TennCare III? **Primary RQ 2.4.c:** Has the percentage of enrollees referred to resources to address non-medical needs affecting enrollees' health increased following the implementation of TennCare III?
Hypothesis 2.5 – Following implementation of the TennCare III demonstration, participant engagement in dental services for eligible TennCare III enrollees will maintain or increase.	**Primary RQ 2.5.a:** Has participant engagement in dental services for TennCare children and adolescents maintained or increased following implementation of TennCare III? **Primary RQ 2.5.b:** Has participant engagement in dental services for pregnant TennCare enrollees maintained or increased following implementation of TennCare III? **Primary RQ 2.5.c:** Has participant engagement in dental services for postpartum TennCare enrollees increased following implementation of TennCare III? **Primary RQ 2.5.d:** Has participant engagement in dental services for adult TennCare enrollees increased following implementation of TennCare III?
Hypothesis 2.6 – Under TennCare III, enrollees will receive Medicaid benefits in excess of those available under the Medicaid State Plan.	**Primary RQ 2.6.a:** What benefits did TennCare enrollees receive that were in excess of the benefits authorized under the Medicaid State Plan following implementation of TennCare III?
Hypothesis 2.7 – DSIPs will continue to provide important services to Tennesseans and expand the provision of health-related services.	**Primary RQ 2.7.a:** What is the amount expended on DSIPs under the demonstration? **Primary RQ 2.7.b:** What additional services and populations served have occurred as a result of freeing up state funds that would otherwise have been used for DSIPs? **Primary RQ 2.7.c:** How much has the State invested in other health-related programs as a result of freeing up state funds that would otherwise have been used for DSIPs?
Hypothesis 2.8 – Following implementation of the TennCare III demonstration, TennCare's UC pools will maintain or increase TennCare enrollee access to eligible safety net providers.	**Primary RQ 2.8.a:** Have TennCare's UC pools maintained or increased access to care for TennCare enrollees served by eligible safety net providers? **Primary RQ 2.8.b:** How has the implementation of TennCare III impacted UC costs?
Hypothesis 2.9 – The retroactive eligibility waiver will not significantly impact	**Primary RQ 2.9.a:** Do Medicaid eligible individuals in Tennessee subject to the retroactive eligibility waiver enroll in Medicaid at the same rates as eligible individuals in other states who have access to retroactive eligibility?

Hypotheses	Research Questions
likelihood of enrollment, health status of enrollees, or have an adverse financial impact.	**Primary RQ 2.9.b:** Does the retroactive eligibility waiver significantly impact likelihood of enrollment continuity for enrollees? **Primary RQ 2.9.c:** Do the health outcomes of enrollees subject to the retroactive eligibility waiver differ from those of enrollees in other states who have access to retroactive eligibility? **Primary RQ 2.9.d:** What are common barriers to timely renewal for enrollees subject to the retroactive eligibility waiver? **Primary RQ 2.9.e:** Do Medicaid eligible individuals in Tennessee subject to the waiver of retroactive eligibility experience greater 'medical debt' relative to members in the program who are exempt from the waiver? **Primary RQ 2.9.f:** Are Medicaid eligible individuals in need of acute care able to enroll in TennCare quickly?
Hypothesis 2.10 – Rates of adoption for children in state custody will increase when Medicaid coverage is available for all children.[4]	**Primary RQ 2.10.a:** Has the implementation of TennCare III (and resulting extension of TennCare coverage to children adopted from state custody) increased the number and percentage of children adopted from state custody?

3. Goal 3: Ensure enrollees' satisfaction with services

The Evaluation will test one hypothesis to evaluate whether TennCare III policies have impacted enrollee satisfaction with services. **Figure 4** outlines the hypotheses and RQs that relate to Goal 3.

Note: Because the majority of TennCare III policies are continued from prior iterations of the TennCare demonstration, it is intended for the independent evaluator to isolate the effects that TennCare III has on these efforts, where feasible.

Figure 4. Goal 3 – Hypotheses and Research Questions

Hypotheses	Research Questions
Hypothesis 3.1 – Following implementation of the TennCare III demonstration, TennCare enrollee satisfaction with health care services will maintain or improve.	**Primary RQ 3.1.a:** Has the implementation of TennCare III maintained or improved TennCare enrollee satisfaction with overall health care? **Primary RQ 3.1.b:** Has the implementation of TennCare III maintained or improved CHOICES enrollee satisfaction? **Primary RQ 3.1.c:** Has the implementation of TennCare III maintained or improved satisfaction of individuals with I/DD? **Primary RQ 3.1.d:** Are parents of children enrolled in the Katie Beckett program satisfied with the services received from TennCare?

[4] The independent evaluator will assess this hypothesis pending CMS's approval of the State's proposal to cover these children.

4. Goal 4: Provide enrollees with appropriate and cost-effective Home and Community-Based Services (HCBS) within acceptable budgetary parameters

The Evaluation will test six hypotheses to evaluate whether TennCare III policies have impacted the provision of appropriate and cost-effective HCBS. **Figure 5** outlines the hypotheses and RQs that relate to Goal 4.

Note: Because the majority of TennCare III policies are continued from prior iterations of the TennCare demonstration, it is intended for the independent evaluator to isolate the effects that TennCare III has on these efforts, where feasible.

Figure 5. Goal 4 – Hypotheses and Research Questions

Hypotheses	Research Questions
Hypothesis 4.1 – Following implementation of the TennCare III demonstration, the proportion of individuals who receive HCBS rather than NF care will maintain or increase.	**Primary RQ 4.1.a:** Has the implementation of TennCare III maintained or increased the number and percentage of CHOICES enrollees actively receiving HCBS? **Primary RQ 4.1.b:** Has the implementation of TennCare III maintained or increased the ratio of HCBS to NF service costs for CHOICES enrollees? **Primary RQ 4.1.c:** Has the implementation of TennCare III maintained or decreased the average LTSS costs per CHOICES enrollee?[5] **Primary RQ 4.1.d:** Has the implementation of TennCare III maintained or increased the number and percentage of individuals with I/DD actively receiving HCBS? **Primary RQ 4.1.e:** Has the implementation of TennCare III maintained or increased the ratio of HCBS to ICF/IID service costs for individuals with I/DD? **Primary RQ 4.1.f:** Has implementation of the TennCare III demonstration maintained or decreased the average LTSS costs per individual with I/DD? **Primary RQ 4.1.g:** Has the implementation of TennCare III maintained or increased the level of institutional transition and diversion for CHOICES enrollees?
Hypothesis 4.2 – Following implementation of the TennCare III demonstration, participation levels in integrated employment for individuals with I/DD will maintain or increase.	**Primary RQ 4.2.a:** Has the implementation of TennCare III maintained or increased the number of individuals with I/DD that participate in integrated employment and earn at or above the minimum wage?
Hypothesis 4.3 – The integration of existing HCBS waivers into managed care will maintain or improve the ability for individuals with	**Primary RQ 4.3.a:** Has the integration of existing HCBS waivers into managed care maintained or improved the ability for individuals with I/DD to choose services?

[5] The independent evaluator will consider impacts of the COVID-19 pandemic, including potential increases in NF payments.

Hypotheses	Research Questions
I/DD to choose services.[6]	
Hypothesis 4.4 – Following enrollment in the Katie Beckett program, access to care for children eligible for Parts A and B of the Katie Beckett program will maintain or improve.	**Primary RQ 4.4.a:** Has enrollment in the Katie Beckett program maintained or improved access to care for eligible children?
Hypothesis 4.5 – Following implementation of the TennCare III demonstration, premium requirements for participants in Part A of the Katie Beckett program will not reduce the likelihood of enrollment or enrollment continuity among participants.	**Primary RQ 4.5.a:** How many and what percentage of children approved for Part A of the Katie Beckett program do not enroll due to non-payment of the premium? **Primary RQ 4.5.b:** How many and what percentage of Katie Beckett Part A program enrollees are suspended from the program due to non-payment of premiums? **Primary RQ 4.5.c:** How many and what percentage of Katie Beckett Part A program enrollees voluntarily separate from the program? **Subsidiary RQ 4.5.c.i:** Among Katie Beckett Part A program enrollees who voluntarily separate from the program, to what extent is this voluntary separation associated with the premium requirements? **Primary RQ 4.5.d:** What is the health insurance status and reported change in health status among Katie Beckett Part A enrollees that were: • Suspended from the program due to non-payment of premiums; or • Voluntarily separated from the program? **Subsidiary RQ 4.5.d.i:** What is the health insurance status and reported change in health status among Katie Beckett Part A enrollees that were suspended from the program due to non-payment of premiums? **Subsidiary RQ 4.5.d.ii:** What is the health insurance status and reported change in health status among Katie Beckett Part A enrollees that voluntarily separated from the program?
Hypothesis 4.6 – Part B of the Katie Beckett program (Medicaid Diversion) will delay and/or divert eligible children from enrolling in TennCare.	**Primary RQ 4.6.a:** Has the implementation of Part B of the Katie Beckett program delayed and/or diverted eligible children from enrolling in TennCare?

5. Goal 5: 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

The Evaluation will test three hypotheses to evaluate whether TennCare III policies have impacted TennCare's ability to 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. **Figure 6** outlines the hypotheses and RQs that

[6] The independent evaluator will assess this hypothesis pending CMS's approval of the State's proposal to integrate these services.

relate to Goal 5.

Figure 6. Goal 5 – Hypotheses and Research Questions

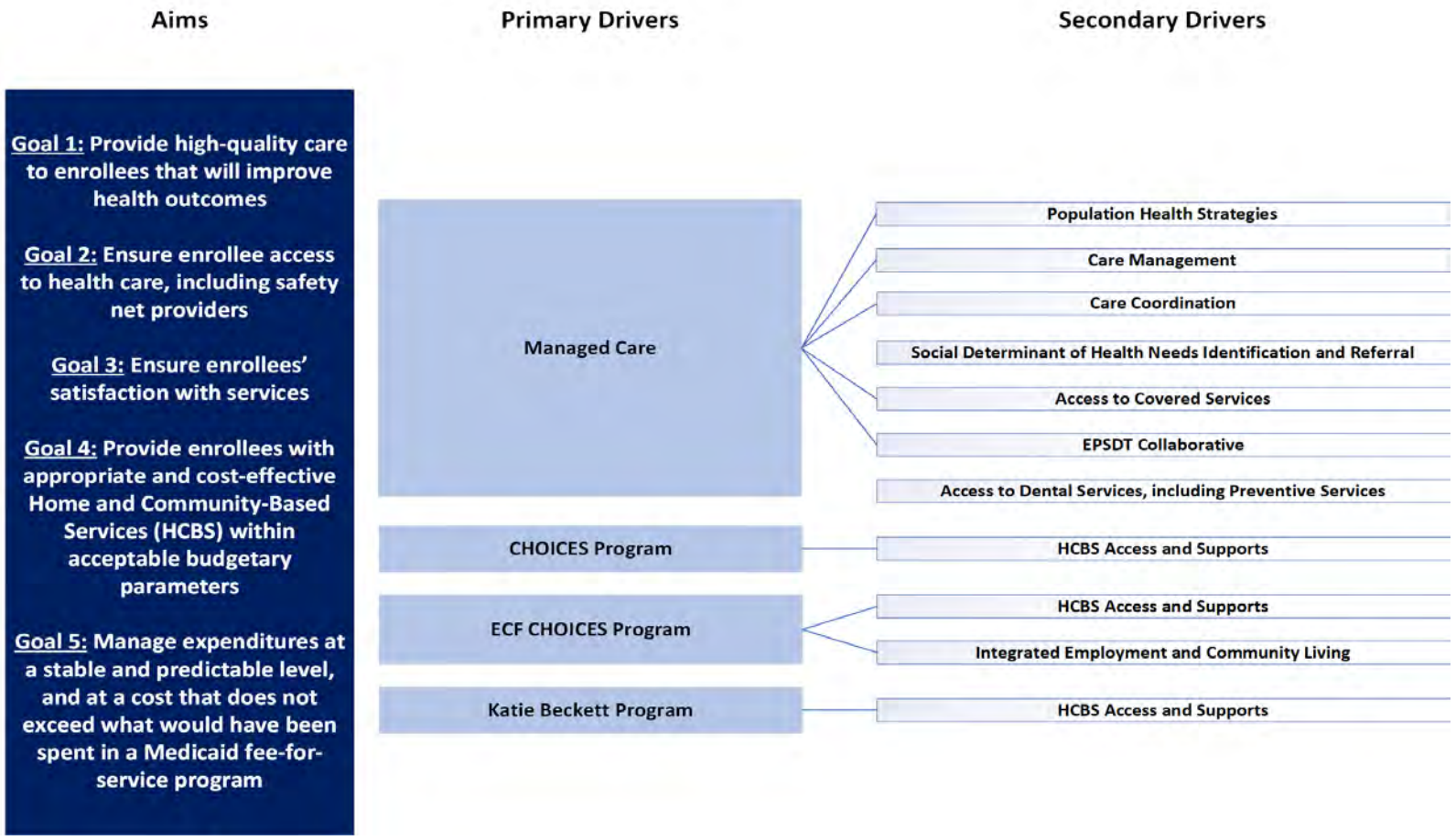
Hypotheses	Research Questions
Hypothesis 5.1 – Following implementation of the TennCare III demonstration, TennCare expenditures will grow at a slower and more sustainable rate than the average national Medicaid expenditures.	**Primary RQ 5.1.a:** Has TennCare maintained an expenditure growth rate that is slower than the average national Medicaid expenditure growth rate?[7] **Primary RQ 5.1.b:** What is the difference between TennCare's aggregate costs by expenditure group compared to the budget neutrality test limits by expenditure group and how does this change over the duration of the demonstration period? **Primary RQ 5.1.c:** What are the administrative operational costs of the demonstration?
Hypothesis 5.2 – Following the implementation of TennCare's authority to suspend Medicaid eligibility for enrollees who have been convicted of Medicaid fraud, the number of Medicaid fraud incidents in State or Local courts will maintain or decrease.	**Primary RQ 5.2.a:** Has the implementation of TennCare's authority to suspend Medicaid eligibility for individuals convicted of Medicaid fraud maintained or decreased the number of enrollees who have been convicted of Medicaid fraud in State or Local courts? **Primary RQ 5.2.b:** What is the reported health insurance status among individuals who are suspended from TennCare due to a Medicaid fraud conviction?

[7] The independent evaluator will consider impacts of the American Rescue Plan, including enhanced Federal Medical Assistance Percentages (FMAP) funds.

6. TennCare III Driver Diagram

The TennCare III Driver Diagram, illustrated in **Figure 7**, establishes a visual relationship between TennCare's five programmatic goals (aims), the primary drivers that advance those goals, and the secondary drivers fundamental to support the primary drivers.

Figure 7. TennCare III Driver Diagram



7. TennCare III Logic Models

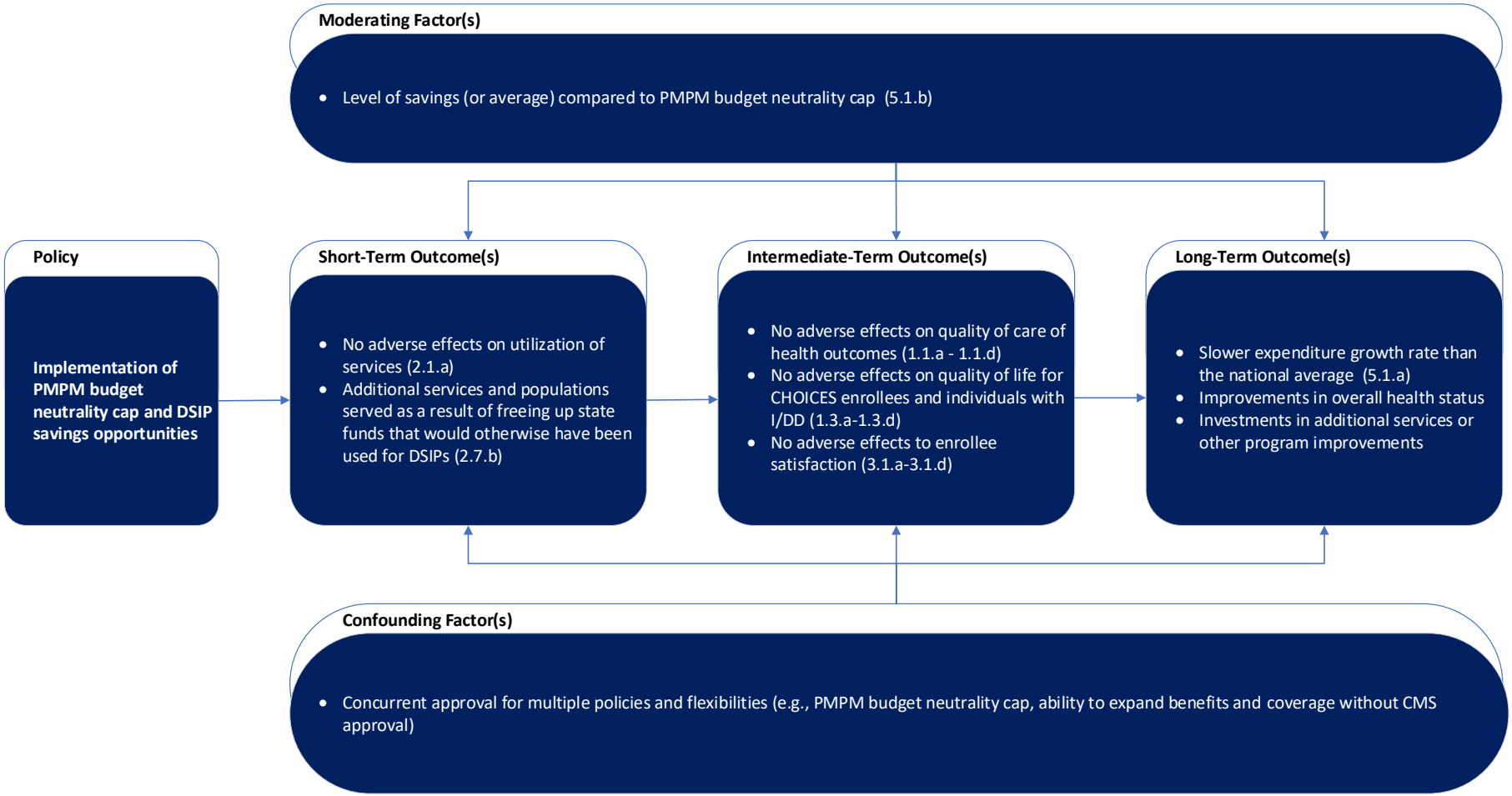
TennCare III Logic Models, included in **Figures 8 and 9** focus on the new, key policies and flexibilities approved as part of the TennCare III demonstration: DSIP savings opportunities and suspension of eligibility for State or Local Medicaid fraud conviction.

Logic Models are not provided for policies that have been in effect since before the approval of TennCare III (e.g., broader managed care programs, CHOICES program, I/DD programs, Katie Beckett/Medicaid Diversion Program).

For each Logic Model, RQs associated with the outcomes, moderating factors, and/or confounding factors are included in parentheses.

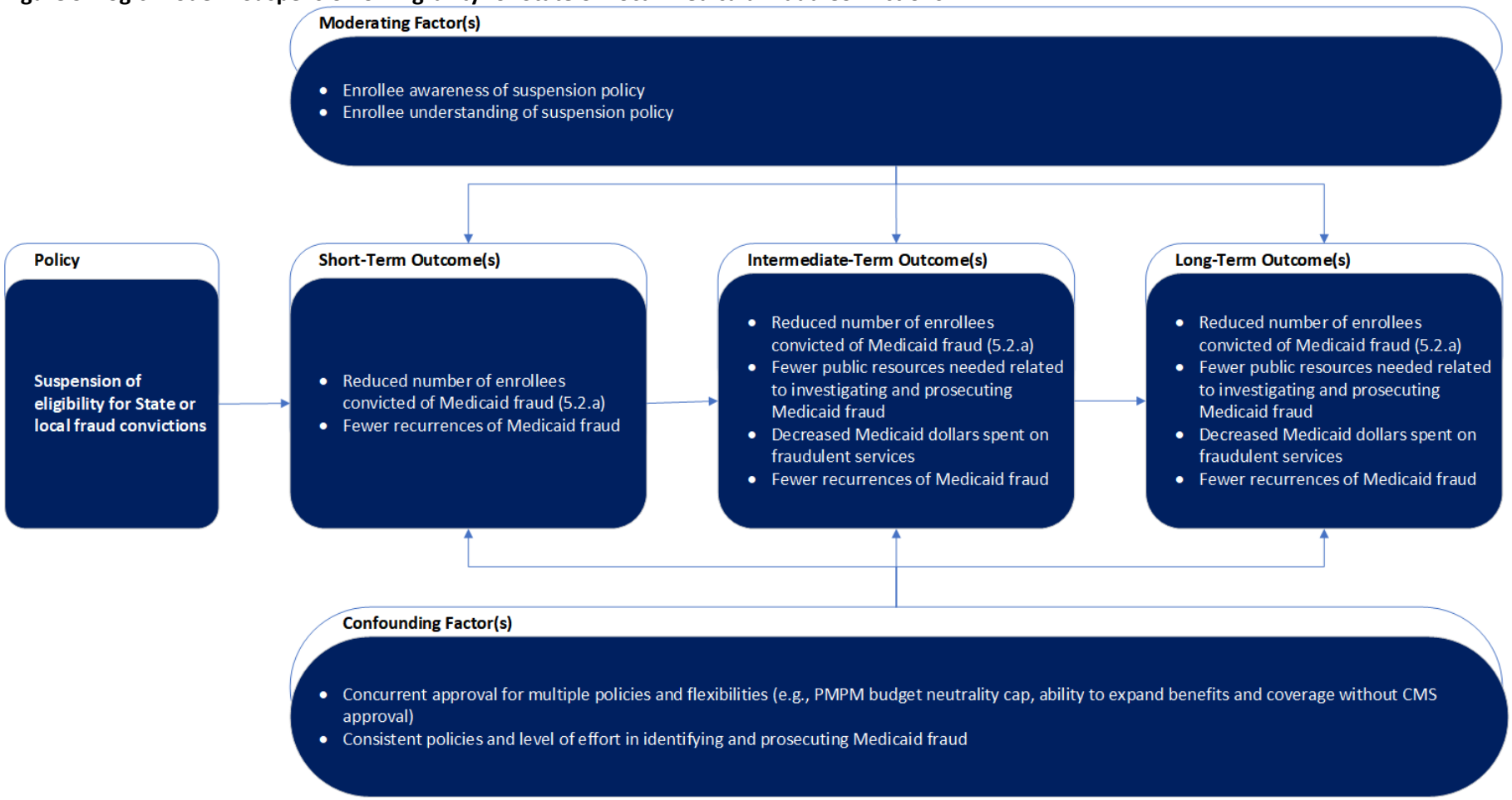
The Logic Model in **Figure 8** illustrates the expected short-term, intermediate, and long-term outcomes for implementation of the DSIP savings opportunities.

Figure 8. Logic Model – Implementation of DSIP Savings Opportunities



The Logic Model in **Figure 9** illustrates the expected short-term, intermediate, and long-term outcomes for the suspension of eligibility for State or Local Medicaid fraud convictions.

Figure 9. Logic Model – Suspension of Eligibility for State or Local Medicaid Fraud Convictions



C. Methodology

This section provides details on the proposed methodology for the TennCare III Evaluation Design, including anticipated data sources, comparison groups, analytic methods, and evaluation reporting periods. The Evaluation Design uses a variety of measures that will track the quality of care, health outcomes, access to care, enrollee satisfaction, and cost-effectiveness of the TennCare program.

Section C.1 summarizes the types of data that the independent evaluator will use.

Sections C.2 and C.3 include the qualitative and quantitative data sources that this Evaluation Design plans to employ, provide a brief description of each, and describe the demonstration topics that the sources will be used to evaluate.

Section C.4 describes TennCare's anticipated target and comparison groups. The TennCare III demonstration is program-wide and thus places all TennCare enrollees in the intervention group for most RQs. As a result, in-state comparison groups are largely infeasible. When possible, the independent evaluator will utilize out-of-state comparison groups for RQs where data can be utilized for comparable states.

Section C.5 outlines TennCare's proposed analytic methods for the Evaluation. The independent evaluator will use a mixed-methods approach to answer the RQs in this Evaluation.

Section C.6 includes analytic tables that detail the evaluation approach for each goal. The analytic tables outline the planned RQs, outcome measures, related data specifications, data sources, comparison groups, analytic approaches, and reporting schedules for each hypothesis.

1. Data Sources

The independent evaluator will compile data for the Evaluation from a range of quantitative and qualitative data sources including national surveys, Tennessee-specific surveys, national claims databases, and state-level claims, administrative, and enrollment data. These data sources are described in further detail in Sections C.2 and C.3.

Figure 10 outlines the data sources anticipated to be used to evaluate each demonstration goal. The "X" indicates the relevant data sources corresponding to each goal.

Figure 10. Data Sources by Demonstration Goal

Data Source	Goal 1: Quality of Care and Health Outcomes	Goal 2: Access	Goal 3: Satisfaction	Goal 4: HCBS	Goal 5: Expenditures
External Data Sources					
1. National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)	X	X			

Data Source	Goal 1: Quality of Care and Health Outcomes	Goal 2: Access	Goal 3: Satisfaction	Goal 4: HCBS	Goal 5: Expenditures
2. National Core Indicators - Aging and Disability™ (NCI-AD) Survey	X		X		
3. NCI Child Family Survey	X		X	X	
4. Council on Quality and Leadership Personal Outcome Measures Survey	X		X	X	
5. Integrated Public Use Microdata Series (IPUMS) American Community Surveys (ACS)		X			
6. Behavioral Risk Factor Surveillance System (BRFSS)		X			
7. Medicaid Budget and Expenditure System (MBES)					X
Internal Data Sources					
1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Data	X				
2. TennCare Claims and Encounter Data	X	X		X	X
3. Pharmacy Claims Data	X	X			X
4. TennCare Dental Benefit Manager (DBM) Claims Data		X			
5. CHOICES and I/DD Program Claims and Encounter Data				X	
6. Tennessee Department of Health Vital Statistics Records (2017-2030)	X				
7. TennCare Provider Enrollment Data	X				
8. State Administrative Data		X			X
9. TennCare MCO Population Health Data		X			
10. Tennessee Uncompensated Care Data		X			
11. TennCare Eligibility and Enrollment Data		X		X	
12. Beneficiary Satisfaction Survey of TennCare Recipients			X		
13. TennCare Individual Employment Data Survey (EDS)				X	
14. TennCare Expenditure Data					X
15. State and Local Law					X

Data Source	Goal 1: Quality of Care and Health Outcomes	Goal 2: Access	Goal 3: Satisfaction	Goal 4: HCBS	Goal 5: Expenditures
Enforcement Agency Data					
16. MCO Interviews		X			
17. TennCare Enrollee Surveys and Focus Groups		X		X	
18. TennCare Medicaid Rules		X			
19. TennCare Benefit Packages		X			
20. Key Informant Interviews and Document Reviews	X	X	X	X	X

2. External Data Source Descriptions

TennCare proposes the use of several external data sources, all of which offer quantitative data. For each of the national surveys, the independent evaluator will consult the survey's technical documentation to ensure effective use of the survey data. If necessary, the independent evaluator may use sample weighting or other sample selection techniques, further outlined in Section C.5.

National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)

The NCQA Quality Compass Data for Medicaid includes HEDIS®, a national data set that measures the quality of care received by Medicaid enrollees. NCQA provides annual national and regional standards that states can use to benchmark their performance on quality and health outcomes through its Quality Compass publication. TennCare's contracted MCOs are required to complete all NCQA HEDIS® measures relevant to Medicaid and report results on an annual basis to TennCare. Each MCO must contract with a NCQA-certified auditor to validate MCO processes.

It is intended for the independent evaluator to use a range of HEDIS® measures to evaluate the impact of the demonstration on overall enrollee quality of care, health outcomes, and service utilization. Many of the HEDIS® measures included in the Evaluation align with CMS' 2021 Adult and Child Core Sets.

National Core Indicators - Aging and Disability™ (NCI-AD) Survey

The NCI-AD Survey is jointly administered by Advancing States, Human Services Research Institute (HSRI), and participating states, and tracks the performance of State Medicaid, aging, and disability agencies. The Survey measures various service planning, community inclusion, safety, and other outcomes of services provided to individuals in participating states. It is intended for the independent evaluator to use NCI-AD Survey results to evaluate MLTSS quality outcomes and satisfaction for the CHOICES population.

Tennessee has participated in the NCI-AD Survey since its launch in measurement year (MY) 2015-2016. In MY 2015-2016, participation results for Tennessee were reported for the general CHOICES population, and not separated by HCBS and NF populations.[8] Therefore, this Evaluation Design proposes to use NCI-AD Survey data beginning in MY 2016-2017, when participation results were separated for the CHOICES HCBS and CHOICES NF populations. NCI-AD Survey data is not available for MY 2020-2021, as the COVID-19 pandemic

[8] NCI-AD 2015-2016 National Results, https://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf

prevented in-person interviews, but data collection is resuming for MY 2021-2022.

Section C.6 includes potential NCI-AD measures that the independent evaluator will evaluate.

National Core Indicators™ (NCI) Child Family Survey

Starting in 2022, Tennessee will begin utilizing the NCI Child Family Survey, a national Survey tool conducted by the same entities as NCI and NCI-AD, for the Katie Beckett program. This data will be compiled on an annual basis and is intended to be used by the independent evaluator to evaluate the impact of the Katie Beckett/Medicaid Diversion program on quality outcomes, care access, and satisfaction for eligible children.

Section C.6 includes potential NCI Child Family measures that the independent evaluator will evaluate.

The Council on Quality and Leadership (CQL) Personal Outcome Measures® (POMs) Survey

The CQL POMs are used to identify people's quality of life outcomes, plan supports, and collect information and data about individual outcomes. The survey gathers information about outcomes in the following factors: My Human Security, My Community, My Relationships, My Choices, and My Goals. The data is intended to be used by the independent evaluator to evaluate quality outcomes and satisfaction of individuals with I/DD.

Section C.6 includes potential CQL POMs measures that the independent evaluator will evaluate.

Integrated Public Use Microdata Series (IPUMS) American Community Surveys (ACS)

The U.S. Census Bureau and U.S. Department of Commerce jointly sponsor ACS, a national annual survey that provides key demographic, insurance, and other socioeconomic variables on the total U.S. population. It is intended for the independent evaluator to use ACS data, including demographic information, employment, disability, income data and Medicaid participation to identify comparable states for comparison for all RQs for which an out-of-state comparison is indicated, and, more specifically, to evaluate whether Medicaid eligible people in Tennessee subject to the retroactive eligibility waiver enroll in Medicaid at the same rates as eligible people in other states who have access to retroactive eligibility.

Behavioral Risk Factor Surveillance System (BRFSS)

Since 1984, the Centers for Disease Control (CDC) and state health departments have jointly operated BRFSS, a nationwide annual survey that gathers large samples of data on health status, health risk behaviors, access to health care, and utilization of preventive health services. Throughout the year, BRFSS interviewers conduct telephone surveys of more than 400,000 adults in all 50 states, the District of Columbia, and three U.S. territories. The contracted interviewers and in-house CDC interviewers conduct the survey using Random Digit Dialing (RDD) techniques on landlines and cell phones.[9]

Medicaid Budget and Expenditure System (MBES)

Through MBES, CMS tracks budgeted and actual State expenditures for each fiscal period and actual expenditures for each quarter. CMS reports on this data in a Financial Management Report every fiscal year. It is intended for the independent evaluator to use this data to evaluate other State Medicaid expenditure growth rates.

[9] Behavioral Risk Factor Surveillance System Frequently Asked Questions, January 2018, https://www.cdc.gov/brfss/about/brfss_faq.htm

Potential Future Data Source: Transformed Medicaid Statistical Information System (T-MSIS)
The State will continue to explore the potential use of T-MSIS data for out-of-state compassion group analyses. However, at this time, the data is not yet available and the independent evaluator will leverage the alternative data sources and analytic methods outlined in this section for the evaluation.

3. Internal Data Source Descriptions
TennCare proposes the use of several internal data sources that will offer both quantitative and qualitative data.

Internal – Quantitative
TennCare's proposed internal, quantitative data sources include a range of Tennessee-specific claims and encounter data, enrollment data, administrative data, and other data sets collected and maintained by the State or its contractors.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Data
On an annual basis, states are required to gather EPSDT data and submit Form CMS-416 to CMS, which helps assess the effectiveness of EPSDT services, including child health screening services, corrective treatment referrals, and dental services. It is intended that the independent evaluator will use EPSDT data to evaluate any changes in EPSDT service utilization among children enrolled in TennCare.

TennCare Claims and Encounter Data
TennCare maintains a database of claims and encounter data that will provide insights on health care utilization patterns of all TennCare enrollees. It is intended for the independent evaluator to use this database to extract data on enrollee utilization of specific services and provider types and other measures of care access and expenditures.

Pharmacy Claims Data
TennCare contracts with OptumRx to gather and maintain pharmacy claims data. It is intended for the independent evaluator to use pharmacy claims to evaluate opioid use, and enrollee utilization of outpatient prescription drugs.

Dental Benefit Manager (DBM) Claims Data
DentaQuest, TennCare's DBM, gathers and maintains dental claims data. It is intended for the independent evaluator to use DBM claims data to evaluate participant engagement in dental services among children, adolescents, and pregnant women.

CHOICES *and I/DD Program Claims and Encounter Data*
It is intended for the independent evaluator to use claims and encounter data to evaluate access to LTSS for CHOICES enrollees and individuals with I/DD, diversion rates from institutional to HCBS care, service costs associated with LTSS, and other measures. LTSS service costs refer to the amounts that TennCare/MCOs pay LTSS service providers.

Tennessee Department of Health Vital Statistics Records
The Tennessee Department of Health Office of Vital Records and Statistics collects and maintains a database of vital statistics, including resident live births. It is intended for the independent evaluator to use the Office's

birth statistics to evaluate the effect of TennCare's opioid strategy on neonatal abstinence syndrome live births.

TennCare Provider Enrollment Data

TennCare collects data on Buprenorphine Enhanced Supportive Medication-Assisted Recovery and Treatment (BESMART) providers enrolled in MCO networks. It is intended for the independent evaluator to use this data to evaluate access to MAT.

State Administrative Data

It is intended for the independent evaluator to use State administrative data to support the evaluation of several measures, including the number and percentage of children adopted from state custody.

TennCare MCO Population Health Data

Since 2020, TennCare has gathered data on non-medical needs affecting enrollees' health from its MCOs through a Semi-Annual MCO Population Health Report. It is intended for the independent evaluator to use the report to evaluate MCO population health efforts, including screenings and referrals to resources. While TennCare has collected the report since 2020, data validity limitations exist for early Population Health Reports; as a result, the first year of data that the independent evaluator would consider for evaluation is CY 2022.

Tennessee Uncompensated Care (UC) Data

UC cost data will be compiled through yearly DSH audits and non-DSH Certified Public Expenditure (CPE) audits. It is intended for the independent evaluator to use this data to measure UC costs associated with eligible Tennessee providers.

TennCare Eligibility and Enrollment Data

It is intended for the independent evaluator to use TennCare eligibility and enrollment data to evaluate the impact that Katie Beckett program premiums and retroactive eligibility waiver have on enrollee access to care, as well as the impact of Katie Beckett Part B on Medicaid diversion for eligible children. This data will also be used to evaluate insurance coverage changes for Katie Beckett program enrollees and enrollees who are subject to the retroactive eligibility waiver.

In addition, it is anticipated that the independent evaluator will use PCMH enrollment data, collected on an annual basis by TennCare, to evaluate enrollee access to comprehensive primary care services.

Beneficiary Satisfaction Survey

Every year since the inception of the TennCare demonstration in 1994, the State has conducted an annual survey of beneficiary satisfaction. This survey was a condition of the original TennCare demonstration and was approved by CMS. The Boyd Center for Business and Economic Research at the University of Tennessee (UT) conducts this beneficiary satisfaction survey annually on behalf of the State. UT surveys Tennessee residents to measure their insurance status, medical service utilization, and level of satisfaction with the TennCare program. The survey has a target sample size of 5,000 households, which enables UT to obtain accurate estimates for subgroups.[10] It is intended for the independent evaluator to use beneficiary

[10] The Impact of TennCare: A Survey of Recipients, October 2019, https://haslam.utk.edu/whitepapers/boyd-center-business-and-economic-research/impact-tenncare-survey-recipients-2019

satisfaction survey data to measure enrollee satisfaction with health care.

TennCare Individual Employment Data Survey (EDS)[11]

The TennCare Individual EDS is administered every calendar year and provides TennCare information on people 62 years of age and under who receive LTSS and are employed or are interested in becoming employed. The survey questions are typically administered by MCO Care Coordinators, Support Coordinators, Case Managers, or Independent Support Coordinators during person-centered planning meetings.[12] Individual EDS data was used to evaluate employment for working age adults with I/DD as part of the TennCare II Evaluation and is intended to be used for the same purpose as part of this Evaluation.

TennCare Expenditure Data

TennCare maintains a database of State Medicaid expenditures, which will be used to evaluate program expenditures throughout the demonstration period.

State and Local Law Enforcement Agency Data

On a quarterly basis, TennCare receives data on the total number of Medicaid fraud convictions from State and Local law enforcement agencies. It is intended for the independent evaluator to use this data to evaluate the impact that suspending eligibility for TennCare enrollees convicted of Medicaid fraud in State or Local courts has on the number of fraud incidents.

Internal – Qualitative

MCO interviews, enrollee surveys, and enrollee focus groups may be conducted to gather qualitative data. Qualitative analysis will provide useful context for the quantitative analyses and will enable the independent evaluator to explore certain trends and outliers in the data.

MCO Interviews

The independent evaluator will conduct interviews with MCOs to evaluate MCO efforts to address non-medical needs affecting enrollees' health. Tennessee will identify MCO interview participants based on existing contacts at each MCO. During these interviews, the independent evaluator will ask questions about strategies to address enrollee access to transportation, housing, food, and other resources that may impact enrollee health.

TennCare Enrollee Surveys and Focus Groups

The independent evaluator will conduct enrollee surveys and focus groups. Enrollee surveys and focus groups are particularly useful where data is not otherwise available on questions of interest.

TennCare Enrollee Surveys

Enrollee surveys will be used to evaluate reported barriers to timely renewal and reported medical debt for enrollees subject to the retroactive eligibility waiver.

Surveys will be distributed via mail and completed using an online form. The enrollee survey

[11] Individual Employment Data Survey, 2021, https://www.tn.gov/content/dam/tn/tenncare/documents/2020EmploymentDataSurvey1.1.2020.pdf

[12] Individual Employment Data Survey, 2021, https://www.tn.gov/content/dam/tn/tenncare/documents/2020EmploymentDataSurvey1.1.2020.pdf

participant selection process will use TennCare enrollment data and member lists. For any internal survey data collection, as feasible given sample size constraints, the independent evaluator will use probability sampling methods to select survey participants. This process will reduce selection bias and strengthen representation of the relevant enrollee subgroups.

The independent evaluator will use weighting methods on enrollee survey data to adjust for non-response and sample design. The independent evaluator will also survey enrollees who are not subject to the retroactive eligibility waiver to serve as a comparison group for the enrollees who are subject to the retroactive eligibility waiver.

Figure 11 outlines the approach, including timeframe, topics, and sampling strategy for the retroactive eligibility enrollee survey. Timeframes and sample sizes will be updated as needed in the methodology section of the evaluation reports.

Figure 11. Summary of TennCare Retroactive Eligibility Enrollee Survey Design

Area	TennCare Retroactive Eligibility Enrollee Survey
Individuals Surveyed	• TennCare enrollees subject to the retroactive eligibility waiver • Comparison group of TennCare enrollees not subject to the retroactive eligibility waiver
Timeframe	2023, 2025, 2027, 2029
Topics	• Barriers to timely enrollment • Presence of medical debt
Mode of Administration	Online survey; distributed as a QR code via physical mail
Sampling Strategy	• Random • Sampling universe: o TennCare enrollees subject to the retroactive eligibility waiver o Comparison group of TennCare enrollees not subject to the retroactive eligibility waiver
Estimated sample size	TennCare enrollees subject to the retroactive eligibility waiver: sample size of 385 Comparison group: sample size to be determined based upon comparison group characteristics
Statistical power assumptions	Assuming a potentially eligible population of approximately 50,000 beneficiaries subject to the retroactive eligibility waiver that enroll or re-enroll in a given year, this sample size will allow for estimating population metrics with a 95% confidence level with a margin of error of +/- 5.0%.

TennCare Focus Groups

The independent evaluator will use focus groups to evaluate reasons for disenrollment from Part A of the Katie Beckett Program, sources of insurance after disenrollment, and changes in health status after disenrollment. Focus groups will be critical when evaluating the Katie Beckett Program as this group has a smaller population and attempting to gather information through surveys would not achieve statistical conclusions. The independent evaluator will develop focus group questions closer to the time of evaluation. The focus groups will use a standardized questionnaire and independent

facilitators. Focus groups may last 30-90 minutes, depending on the number of questions, to ensure that each topic is sufficiently addressed and discussed among participants.

Figure 12 summarizes the planned approach for focus groups.

Figure 12. Summary of Focus Groups

Focus Group	Potential Topics and Insights	Timeframe
Beneficiaries in the Katie Beckett Program that were suspended from the program due to non-payment of premiums or voluntarily separated from the program	Reasons for disenrollment from Part A of the Katie Beckett Program, sources of insurance after disenrollment, and changes in health status after disenrollment.	Each interim evaluation report year

TennCare Medicaid Rules

The flexibilities afforded under TennCare III allow the State to add new benefits and coverage without prior CMS approval. In the case of amended Medicaid benefits and/or coverage, TennCare will alter Medicaid Rules as necessary and the independent evaluator will report on any applicable changes to the Medicaid rules in the Evaluation Report(s).

Note: TennCare is not authorized to make reductions to benefits or coverage without prior CMS approval.

TennCare Benefit Packages

TennCare provides a variety of benefit packages that vary based on eligibility group. As noted above, TennCare may add to these benefits without prior CMS approval. TennCare will update the benefit packages to reflect any additions to benefits and/or coverage. The independent evaluator will report on any applicable changes to the benefit packages in the Evaluation Report(s).

Key Informant Interviews and Document Reviews

In addition to the data sources named above, the independent evaluator will incorporate key informant interviews and document reviews into the evaluation to provide insights on the impact of the demonstration. The independent evaluator will conduct semi-structured interviews with key stakeholders, including TennCare staff, to gain insights as to the real-world effects of the demonstration and its impact on beneficiaries. The independent evaluator will also review documents such as TennCare's quarterly monitoring reports and other relevant publications to gain insight into changes in the delivery system or other descriptions of context related to programs and policies. The key informant interviews and document reviews will primarily serve as a supplemental data source to bolster and contextualize quantitative metric findings across goals, hypotheses, and research questions.

4. Target and Comparison Populations

Target Populations

The target population for this analysis is all beneficiaries covered by TennCare, or where applicable, the TennCare member subgroup specific to the RQ, such as:

- *CHOICES:* The CHOICES program covers older adults and adults with physical disabilities. To qualify for CHOICES, beneficiaries must need the level of care provided in a NF and qualify for Medicaid LTSS.
- *Programs for Individuals with I/DD:* Programs for individuals with I/DD include ECF CHOICES, 1915(c) waivers, and ICF/IID services. Beneficiaries must meet the definition of intellectual disability or

developmental disability.

- *Katie Beckett/Medicaid Diversion:* The Katie Beckett program covers children with disabilities or complex needs through age 18 with disabilities and/or complex medical needs who are not otherwise Medicaid eligible due to their parents' income or assets.

Comparison Populations

Comparison populations are used in program evaluation and impact assessment to serve as a counterfactual group from the intervention group where the intervention is not applied. The use of a counterfactual group supports a quasi-experimental study in circumstances where an experimental design (e.g., randomized control trial) would be unethical or infeasible.

During the development of the Evaluation Design, both in-state and out-of-state comparison groups were considered. There are several aspects of the demonstration that render in-state comparison groups largely infeasible for this Evaluation Design:

1. Many of the demonstration components impact the entire TennCare enrollee population. In these cases, all in-state enrollee populations must be considered part of the intervention group.
2. For the components that target specific subgroup, such as the Katie Beckett program, the unique characteristics of the target population limit the availability of appropriate in-state comparison groups.
3. None of the new demonstration components involve random assignment or staggered implementation.
4. Tennessee does not actively maintain an all-payer claims database from which to identify a comparable in-state low-income non-Medicaid population.

For these reasons, when using comparison groups, the Evaluation Design plans to use either beneficiaries with similar characteristics from other states (selected using methodology described below) or national/regional benchmarks as the potential comparison group for quasi-experimental analyses, depending on the RQ.

Out-of-State Comparison Groups

To select the out-of-state comparison groups, the independent evaluator will first select states similar to Tennessee on relevant characteristics, such as overall demographics and Medicaid policies. The independent evaluator will use data sources such as ACS or BRFSS to find states similar to Tennessee on key state characteristics, such as percent unemployed, Medicaid eligibility Federal Poverty Level cut-off points, percent uninsured, race composition, percent Medicaid enrollees covered by MCOs, and health status on key indicators. Comparison states and selection criteria may differ depending on the RQ (e.g., for RQs regarding the retroactive eligibility waiver, comparison states will provide retroactive coverage to serve as an appropriate counterfactual).

Specifically, to identify similar states, the independent evaluator will compute a similarity score that is the inverse of the Euclidean distance between Tennessee and the potential comparison states. The independent evaluator will identify the relevant covariates, such as those listed above, compute the Euclidean distance with each covariate treated as a dimension between Tennessee and the other states, and select the comparison State with the lowest distance metric relative to Tennessee.[13]

[13] See Stuart, E. A. (2010). Matching methods for causal inference: A review and a look forward. *Statistical science: a review journal of the Institute of Mathematical Statistics*, *25*(1), 1.

As part of the Interim and Summative Evaluation Reports, the independent evaluator will follow the methodology outlined to determine the appropriate states to use as comparisons, using the data sources and variables in **Figure 13**. The independent evaluator may choose to vary the final states selected by research question and may choose to add or otherwise change the set of variables included in the Euclidian matching model to reflect any updated, state-specific policy changes.

Figure 13. Summary of State Characteristics and Variables for Euclidian Matching Model to Select Comparison States

Characteristic	Data Source	Variable Name
Population Estimate	ACS	Population Estimate, July 1, 2021
Medicaid expansion status	KFF[14]	N/A
Percent FPL Limit (Parents, as of January 1, 2022)	KFF	N/A
Min Wage	DOL[15]	N/A
Percent Urban Population	BRFSS	_URBSTAT
Percent Medicaid Coverage	BRFSS	HLTHCVR1
Marketplace Type	KFF	N/A
Demographics	ACS	S2502_C01_002E through S2502_C01_010E
Unemployment Rate	BRFSS	EMPLOY1
Uninsured Pct of Population	ACS	DP03_0097PE, DP03_0098PE, DP03_0099PE
Percent with cash public assistance income	ACS	DP03_0073PE
Percent of Enrollees with Disabilities	KFF	N/A
MLTSS in place	KFF	N/A
Percent of enrollees in MLTSS	KFF	N/A
Percent using cigarettes	BRFSS	SMOKDAY2
Percent obese	BRFSS	_BMI5CAT
Percent under 100% FPL	KFF	N/A

Where complete and accurate beneficiary-level data are available, the independent evaluator will select the comparison group of similar Medicaid enrollees from the selected comparison state(s). To improve the validity of the difference-in-differences (DiD) analyses, discussed further below, and support the use of an out-of-state comparison group where Medicaid populations may differ in characteristics, the independent evaluator will consider the use of propensity score matching to select the comparison group. Specifically, the independent evaluator will match beneficiaries in the intervention group with beneficiaries from the selected comparison state(s).

National/Regional Benchmarks

For data sets where beneficiary-level data are not available, state-level aggregate measures or national/regional benchmarks may be used as a comparison. These benchmarks can serve as a comparison in the pre- and post-intervention periods, supporting a DiD evaluation. The independent evaluator will use the method described under Out-of-State Comparison Groups above to select appropriate states or regions to serve as comparison benchmarks. When aggregate measures or national/regional benchmarks are used, the independent evaluator will identify the necessary covariates to include in the model to control for differences

[14] Kaiser Family Foundation (2022). Various indicators, "State Health Facts." Accessed August 17, 2022 from https://www.kff.org/statedata/.

[15] Paycor (2022), based on Department of Labor data. "Minimum Wage by State and 2023 Increases." Accessed August 17, 2022 from https://www.paycor.com/resource-center/articles/minimum-wage-by-state/.

between Tennessee and the selected comparison benchmarks. The independent evaluator will use both relevant theory/research and data-driven techniques to inform the selection of the relevant covariates.

5. Analytic Methods

The independent evaluator will use a mixed-methods approach to answer the RQs in this Evaluation. To assess program impact, the Evaluation Design uses a quasi-experimental, quantitative methodology where feasible to allow for causal interpretation of results. The independent evaluator will also use qualitative analyses to support an understanding of stakeholders' perspectives and experiences on implementation and outcomes. The quantitative and qualitative analyses will complement each other and present a comprehensive assessment of the TennCare III implementation, impact, and variation among subgroups. The independent evaluator will use a convergent mixed methods approach to incorporating qualitative and quantitative methods. In a convergent approach, qualitative and quantitative data are collected in a similar timeframe, and each type of data may inform the collection, analysis, and interpretation of the other in an iterative fashion. For example, focus groups with Katie Beckett enrollees may provide contextual information to use when interpreting Katie Beckett eligibility and enrollment data, and the analysis of the Katie Beckett eligibility and enrollment data may inform the development of interview guides for focus groups. The independent evaluator should collect and analyze both quantitative and qualitative data throughout the evaluation period.

The following analytic methods will be considered for this Evaluation.

Difference-in-Differences

The Evaluation Design uses a quasi-experimental, quantitative design to estimate the causal impact of the TennCare III implementation and policy changes wherever possible. Specifically, for RQs where there are pre-intervention data and a valid comparison group identified, the independent evaluator will use DiD. DiD is a regression technique that measures the impact of an intervention by comparing changes in outcomes for the target population to changes in outcomes for a comparison group. Using DiD, the impact of TennCare III can be isolated as the pre-post difference in an outcome for the intervention group minus the pre-post difference for the comparison group (see methodology described above for comparison group selection).

The identifying assumption for DiD requires "parallel trends," which specifies that the change in the intervention group would have been the same as the change in the comparison group if the intervention (i.e., TennCare III) had not been applied. Violations of this assumption (e.g., the outcome of interest in the comparison state is affected by a separate policy that changes the trend from baseline) will limit the validity of any causal inference from a DiD methodology. Out-of-state comparison groups will be selected with the "parallel trends" criterion in mind, and the independent evaluator will conduct visual trend analysis and other statistical testing to ensure the assumption holds during the baseline period for the selected comparison states.

The independent evaluator will use standard power calculations to assess the appropriate sample size for model specifications. The DiD regression models will include beneficiary and geographic-level covariates to control for underlying differences; the covariates will include demographic characteristics, health status, regional and location data, and other variables as relevant and available. Additionally, as appropriate, the independent evaluator will apply sampling weights and weighting techniques to any survey sample data sources used. Unless otherwise specified, the DiD analysis will use a baseline period of 2017-2019 and an intervention period of 2021 forward.

For hypotheses and research questions for policy components that remain unchanged between TennCare II and TennCare III (e.g., CHOICES), it is less likely that a significant change in utilization or other outcomes will be observed between the two demonstrations. Ideally, in these scenarios, the independent evaluator would be able to use pre-period data to address questions about impacts or changes; however, for policies that have been longstanding features of the TennCare Demonstration, the ability to use or access pre-period data is limited or infeasible. In those cases, the independent evaluator can use DiD (or pre-test/post-test), but the results must be specifically interpreted with limited ability for causal inference. In these cases, the addressed policy component's intervention is not being tested due to the absence of pre-period (pre-TennCare) data; instead, the results should be interpreted as attributed to the change between TennCare II and TennCare III. Additionally, any features of the TennCare Demonstration that pre-dates the approval of TennCare III have been assessed in CMS-approved evaluations in earlier Demonstration periods.

Interrupted Time Series

Where valid in-state and out-of-state comparison groups are unavailable due to data limitations but extended pre-intervention data are available, the independent evaluator will use an interrupted time series (ITS) design. ITS estimates the impact of an intervention based on the pre-intervention and post-intervention period, using a longitudinal measure of the outcome of interest. ITS requires observations on the target population taken at equal intervals over a time period during which the intervention is implemented (the "interruption"). By repeatedly observing the measure before and after the intervention, the independent evaluator can assess whether the level or trend of the outcome has shifted. If there are sufficient pre-intervention observations and adequate statistical power, ITS may support causal interpretation.

Due to the long intervention period expected for the demonstration (i.e., 10 years) and the balanced observation requirement, utilizing a formal ITS design may not be feasible for many RQs. Many measures in available data sets may not have been collected for the entire pre-intervention period, or certain outcome measures may be affected by other events (e.g., separate policy change or recession), rendering any conclusions invalid. Like DiD, it is necessary to conduct visual trend analysis on the pre-intervention period to ensure linearity of the trends and the absence of seasonal effects. Additionally, using regression analysis with relevant covariates can strengthen the ITS design by controlling for other potential confounding external factors; the covariates should include demographic characteristics, health status, regional and location data, and other variables as relevant and available.

One-Group Pretest-Posttest

In many cases, there are insufficient data points before the implementation of TennCare III to support an ITS design, which requires balanced data points surrounding the intervention period. For these questions, the independent evaluator will compare rates/measures calculated before and after the implementation of TennCare III to assess changes in a one-group pretest-posttest design. This design does not permit a causal interpretation; however, the independent evaluator can use this analysis to estimate trends in the outcome of interest following the implementation of the intervention. The evaluator will use regression techniques to control for changes in enrollee characteristics over time to improve the estimation of the trend in the measured outcome.

Comparison of Means

In instances where a comparison group or national/regional benchmark are available for the selected measure, but pre-intervention data are limited or unavailable, the Evaluation Design incorporates a

comparison of means (i.e., post-test only with non-equivalent comparison group). This design estimates changes in the outcome of interest for the intervention group against the comparison group over time. Where applicable, the independent evaluator will incorporate regression techniques to control for observable characteristics and potential confounding variables to support an improved comparison. Additionally, the independent evaluator will leverage statistical tests to test for the significance of findings (e.g., Chi-squared tests). However, because this analysis does not control for pre-intervention trends that could continue during the intervention period, the conclusions will not support causal inference and will be limited to observational trends regarding the outcomes of interest.

Descriptive Analyses and One-Group Posttest-Only

For measures without pre-intervention data, the Evaluation Design is limited to summary statistics and observational (non-causal) inference on trends from the baseline period. For RQs assessing beneficiary characteristics, service utilization, or other descriptive variables, the independent evaluator will calculate standard summary statistics (e.g., total, median, mean, etc.) to report findings. Where appropriate, the independent evaluator will use statistical tests (e.g., Chi-Squared test) to assess the statistical significance of findings and differences between subgroups.

The independent evaluator will use a one-group posttest-only design to analyze measures without pre-intervention data or a comparison group over time. This analysis will describe change in the outcome of interest for the target population from baseline over time, but the assessment will be limited by the lack of pre-intervention data. Where appropriate, the evaluator will use regression techniques to control for changes in enrollee characteristics over time to improve the estimation of the trend in the measured outcome.

Qualitative Analysis

The independent evaluator will collect qualitative data through methods such as focus groups and stakeholder interviews. The qualitative data will be categorized and coded systematically using a standard qualitative methodology or software. The independent evaluator will use thematic analysis, which is a systematic and iterative data coding and analysis process that will allow the independent evaluator to identify themes or patterns within the responses.

Subgroup Analysis

To supplement the recommended methodologies, the independent evaluator will conduct subgroup analysis that examines the findings by population subsets where appropriate. The independent evaluator will use DiD and ITS analyses to estimate the average causal impact of the TennCare III implementation; however, this impact may vary depending on beneficiary subgroups (e.g., eligibility category, income level, duration of enrollment, rural/urban regions, etc.). Subgroup analysis allows further exploration of the potential impact by segmenting the target population to identify differences in impact. The independent evaluator will determine the number and type of subgroup analyses based on the demonstration goals, the RQs, and data and sample size limitations. Additionally, results of descriptive analyses should inform the subgroups considered.

The ability to conduct subgroup analysis may be limited by statistical and data considerations, such as sample size/power, sample variance, and available data variables. The independent evaluator will balance the potential insights and benefit of subgroup analysis against the potential statistical limitations to develop a precise and accurate analysis. When applying subgroup analysis to RQs where comparison groups are used, the independent evaluator will test whether subgroups of TennCare III beneficiaries and the comparison group are adequately balanced across key characteristics; if needed, the independent evaluator will construct

subgroup-specific comparison groups to ensure balance in observable characteristics.

6. Analytic Tables

Figures 14-18 outline the hypotheses, RQs, outcome measures, related data specifications, data sources and timeframes, comparison groups, analytic approaches, and reporting schedules for each demonstration goal.

Figure 14. Analytic Table – Goal 1: Provide high-quality care to enrollees that will improve health outcomes

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 1.1 – Following implementation of the TennCare III demonstration, quality of care and health outcomes for TennCare enrollees will maintain or improve.						
Primary RQ 1.1.a: Has the implementation of TennCare III maintained or improved physical health outcomes for TennCare enrollees?	- Controlling High Blood Pressure	- Numerator: number of enrollees 18–85 years of age who had a diagnosis of hypertension and had adequately controlled blood pressure (<140/90 mm Hg) - Denominator: the eligible population	- NCQA HEDIS® (2017-2030)	- National / regional benchmarks	- Difference-in-differences - Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	- Numerator: number of enrollees 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%) - Denominator: the eligible population				

Primary RQ 1.1.b: Has the implementation of TennCare III maintained or increased the utilization rates of preventive or wellness services for TennCare enrollees?	- Cervical Cancer Screening	- Numerator: number of female enrollees 21–64 years of age who were screened for cervical cancer using any of the following criteria:
		  - Female enrollees 21–64 years of age who had cervical cytology performed within the last 3 years
		  - Female enrollees 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years
		  - Female enrollees 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
		- Denominator: the eligible female population
			- NCQA HEDIS® (2017-2030)	- National / regional benchmarks	- Difference-in-differences
					- Descriptive analysis
						- First Interim Evaluation (2023)
						- Second Interim Evaluation (2026)
						- Third Interim Evaluation (2029)
						- Summative Evaluation (2032)

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
	- Well-Child Visits in the First 30 Months of Life, First 15 Months[16]	Rate 1 – Well-Child Visits in the First 15 Months - Numerator: number of enrollees with six or more well-child visits with a PCP on different dates of service on or before the 15-month birthday - Denominator: The Rate 1-eligible population Rate 2 - Well-Child Visits for Age 15 Months–30 Months - Numerator: number of enrollees with two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday - Denominator: The Rate 2-eligible population				
	- Child and Adolescent Well-Care Visits	- Numerator: number of enrollees ages 3-21 with one or more well-care visits during the MY - Denominator: the eligible population				
	- Childhood Immunization Status, Combo 10	- Numerators: number of enrollees 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday - Denominator: the eligible population				

[16] As of 2020, Well-Child Visits in the First 30 Months of Life contains two rates.

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Primary RQ 1.1.c: Has the implementation of TennCare III maintained or increased the utilization rates of EPSDT services for TennCare enrollees?	- EPSDT Screening ratio	- Numerator: total EPSDT screenings received by eligible enrollees, by age group - Denominator: total expected number of screenings, by age group	- EPSDT Data (2017-2030) - Annual National EPSDT Data (2017 – 2030)	- National / regional benchmarks	- Difference-in-differences - Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- EPSDT Participant ratio	- Numerator: total eligible enrollees receiving at least one initial or periodic screening - Denominator: total eligible enrollees who should receive at least one initial or periodic screening				
Primary RQ 1.1.d: Has the implementation of TennCare III maintained or improved the management of BH conditions for TennCare enrollees?	- Follow-Up after Hospitalization for Mental Illness (Adults)	- Numerator: number of enrollees 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a MH provider within 30 days after discharge - Denominator: the eligible population	- NCQA HEDIS® (2017-2030)	- National / regional benchmarks	- Difference-in-differences - Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Follow-up after Hospitalization for Mental Illness (Children)	- Numerator: number of enrollees ages 6 to 18 older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a MH provider within 30 days after discharge - Denominator: the eligible population				
Hypothesis 1.2 – Following implementation of the TennCare III demonstration, opioid misuse will maintain or decrease among TennCare enrollees, access to MAT will maintain or increase, and health outcomes associated with opioid misuse will maintain or improve.						
Primary RQ 1.2.a: Has the implementation of TennCare III maintained or decreased opioid use among TennCare enrollees (i.e., first-time, acute, and chronic opioid users)?	- Number of Opioid Users – First Time	- Number of unique enrollees receiving an opioid prescription for the first time, annually	- Pharmacy Claims Data (2017-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Number of Opioid Users – Acute	- Number of unique enrollees that have received less than a 90-day quantity of prescribed opioids in the 180 days period immediately preceding the opioid's prescription day, annually				
	- Number of Opioid Users - Chronic	- Number of unique enrollees that have received more than a 90-day quantity of prescribed opioids in the 180 days period				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
		immediately preceding the opioid's prescription day, annually				
	- Number of Opioid Prescriptions per 1,000 Members	- Numerator: total number of opioids prescriptions in a MY x 1,000 - Denominator: total number of unique enrollees in the same year				
	- Days' Supply of Opioid Prescriptions	- Average days' supply of opioid prescriptions to enrollees annually				
Primary RQ 1.2.b: Has the implementation of TennCare III maintained or decreased the number of Neonatal Abstinence Syndrome live births?	- Neonatal Abstinence Syndrome Live Births	- Total annual number of live births associated with neonatal abstinence syndrome	- TennCare Claims and Encounter Data (2017-2030) - Tennessee Department of Health Vital Statistics Records (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 1.2.c: Has the implementation of TennCare III maintained or improved the rate of OUD treatment for TennCare enrollees?	- Use of Pharmacotherapy for OUD	- Numerator: number of enrollees ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the MY - Denominator: number of enrollees with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the MY	- NCQA HEDIS® (2022-2030)	- National/regional benchmarks	- Difference-in-differences - Descriptive analysis	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 1.2.d: Has the implementation of TennCare III maintained or improved access to MAT?	- Total number of unique providers in BESMART program	- Total number of unique providers in BESMART program across all MCOs	- TennCare Provider Enrollment Data (2019-2030) - TennCare Claims and Encounter Data (2019-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Total number of unique TennCare enrollees served in BESMART program	- Total number of unique TennCare enrollees served in BESMART program				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 1.3 – Following implementation of the TennCare III demonstration, quality outcomes and quality of life for TennCare CHOICES and individuals with I/DD will maintain or improve.						
Primary RQ 1.3.a: Has the implementation of TennCare III maintained or improved quality outcomes for CHOICES enrollees?	- Percentage of people who know how to manage their chronic conditions	- Numerator: number of people who reported they know how to manage their chronic conditions (Response Options: Yes, In-Between/Some Conditions, No, Don't Know, Unclear/Refused/No Response) - Denominator: total number of respondents	- NCI-AD Survey (MY 2016-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Percentage of people whose health was described as having gotten better compared to 12 months ago	- Numerator: number of people whose health was described as having gotten better compared to 12 months ago (Response Options: Much Worse, Somewhat Worse, About the Same, Somewhat Better, Much Better, Don't Know, Unclear/Refused/No Response) - Denominator: total number of respondents				
Primary RQ 1.3.b: Has the implementation of TennCare III maintained or improved quality of life for CHOICES enrollees?	- Percentage of people who feel in control of their life	- Numerator: number of people who feel in control of their life (Response Options: Less, About the Same, More, Don't Know, Unclear/Refused/No Response) - Denominator: total number of respondents				
	- Percentage of people who feel the services they receive help them live the life they want	- Numerator: number of people who reported they feel that the services they receive help them live the life they want (Response Options: No, Yes, Don't Know, Unclear/Refused/No Response) - Denominator: total number of respondents				
Primary RQ 1.3.c: Has the implementation of TennCare III maintained or improved quality outcomes for individuals with I/DD?	- Percentage of people who report they have the best possible health (POM 3)	- Numerator: number of respondents who have the best possible health, as individually defined by that person - Denominator: total number of survey respondents who provided valid answers to the survey question	- CQL POMs Survey (MY 2025-2030)	- Respondents to CQL POMs Survey in other states	- Descriptive analysis followed by difference-in-differences in later years	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Percentage of people who report living in integrated environments (POM 9)	- Numerator: number of respondents who use the same environments as people without disabilities - Denominator: total number of survey				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
		respondents who provided valid answers to the survey question				
	- Percentage of people who report they are respected (POM 7)	- Numerator: number of respondents who are treated with respect by people in their lives - Denominator: total number of survey respondents who provided valid answers to the survey question				
Primary RQ 1.3.d: Has the implementation of TennCare III maintained or improved quality of life for individuals with I/DD?	- Percentage of people who report they choose where and with whom they live (POM 17)	- Numerator: number of respondents who choose where they live and who they live with - Denominator: total number of survey respondents who provided valid answers to the survey question				
	- Percentage of people who report they choose where they work (POM 18)	- Numerator: number of respondents who choose where they work or what they do during the day - Denominator: total number of survey respondents who provided valid answers to the survey question				
	- Percentage of people who report having friends (POM 13)	- Numerator: number of respondents who have friends and are satisfied with the number and amount of contact with friends - Denominator: total number of survey respondents who provided valid answers to the survey question				
	- Percentage of people who report they exercise their rights (POM 5)	- Numerator: number of respondents who exercise their human, civil, and other rights - Denominator: total number of survey respondents who provided valid answers to the survey question				
	- Percentage of people who report they use their environments (POM 8)	- Numerator: number of respondents who are not limited by physical or environmental barriers at home, work, or in the community - Denominator: total number of survey respondents who provided valid answers to				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
		the survey question				
Hypothesis 1.4 – Following enrollment in the Katie Beckett program, quality of life, family outcomes, and health outcomes will maintain or improve for children eligible for Parts A and B of the Katie Beckett program.						
Primary RQ 1.4.a: Has enrollment in the Katie Beckett program maintained or improved quality of life for eligible children?	- Percentage of family respondents who feel that services and supports have made a positive difference in the life of their child	- Numerator: number of family respondents who reported that services and supports have made a positive difference in the life of their child (Response Options: Yes, No) - Denominator: total number of family respondents	- NCI Child Family Survey (MY 2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Percentage of family respondents who report that services and supports are helping their child to live a good life	- Numerator: number of family respondents who reported that services and supports are helping their child to live a good life (Response Options: Yes, No) - Denominator: total number of family respondents				
Primary RQ 1.4.b: Has enrollment in the Katie Beckett program maintained or improved health and family outcomes for eligible children?	- Percentage of family respondents who report that services and supports have reduced their family's out-of-pocket expenses for their child's care	- Numerator: number of family respondents who reported that that services and supports have reduced their family's out-of-pocket expenses for their child's care (Response Options: Yes, No) - Denominator: total number of family respondents	- NCI Child Family Survey (MY 2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Percentage of family respondents who report family supports have improved their ability to care for their child	- Numerator: number of family respondents who reported that family supports have improved their ability to care for their child (Response Options: Yes, No) - Denominator: total number of family respondents				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 1.5 –Following implementation of the TennCare III demonstration, costs associated with treating conditions related to diapers for children under age 2 will decrease, as will the rates of those conditions.						
Primary RQ 1.5.a: Has the implementation of TennCare IIII decreased the costs associated with the treatment of diaper rash/diaper dermatitis, as well as the rates of those conditions, in children under age 2?	- Monthly costs associated with treatment of diaper rash/diaper dermatitis in children under age 2 - Monthly rates of diaper rash/diaper dermatitis in children under age 2	- Comparison of relevant costs during the period prior to the implementation of the diaper benefit with costs following the implementation of the diaper benefit - Comparison of rates of diaper rash/diaper dermatitis during the period prior to the implementation of the diaper benefit with rates following the implementation of the diaper benefit	- TennCare Encounter and Claims Data (2019-2030)	- Not applicable	- Interrupted time series design	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 1.5.b: Has the implementation of TennCare IIII decreased the costs associated with the treatment of UTIs, as well as the rates of UTIs, in children under age 2?	- Monthly costs associated with treatment of UTIs in children under age 2 - Monthly rates of UTIs in children under age 2	- Comparison of relevant costs during the period prior to the implementation of the diaper benefit with costs following the implementation of the diaper benefit - Comparison of UTI rates during the period prior to the implementation of the diaper benefit with UTI rates following the implementation of the diaper benefit	- TennCare Encounter and Claims Data (2019-2030)	- Not applicable	- Interrupted time series design	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Figure 15. Analytic Table – Goal 2: Ensure enrollee access to health care, including safety net providers

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 2.1 – Following implementation of the TennCare III demonstration, enrollee utilization of services will maintain or improve.						
Primary RQ 2.1.a: Has the implementation of TennCare III maintained or improved enrollee utilization of services?[17] • Primary care visits • Inpatient visits • BH visits • Prescription drugs	See subsidiary questions below.	See subsidiary questions below.	See subsidiary questions below.	See subsidiary questions below.	See subsidiary questions below.	See subsidiary questions below.

[17] The independent evaluator will examine whether observed changes in service utilization measures suggest that the volume and mix of services utilized is shifting in the direction of lower cost types of care, when clinically appropriate (e.g., if increased primary care visits are observed, if there is an association between primary care visit rates and emergency department visit and inpatient visit rates). The independent evaluator will interpret the service utilization measures in the context of other measures in the Evaluation (e.g., health outcome measures).

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Subsidiary RQ 2.1.a.i: Has the implementation of TennCare III maintained or improved utilization of primary care?	- Adults' Access to Preventive / Ambulatory Health Services	- Numerator: number of members 20 years and older who had one or more ambulatory or preventive care visit during the measurement year - Denominator: the eligible population	- NCQA HEDIS® (2017-2030)	- National/regional benchmarks	- Difference-in-differences - Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Subsidiary RQ 2.1.a.ii: Has the implementation of TennCare III maintained or improved utilization of inpatient care?	- Total Inpatient – Inpatient Discharges per 1,000 Member Months	- Numerator: number of acute inpatient discharges during the measurement year x 1,000 - Denominator: total number of unique enrollees in the same year	- NCQA HEDIS® (2017-2030)	- National/regional benchmarks	- One group pretest-posttest - Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Subsidiary RQ 2.1.a.iii: Has the implementation of TennCare III maintained or improved utilization of BH treatment?	- Mental Health Utilization – Services per 1,000 Member Months	- Numerator: number of members receiving any mental health service (including inpatient, intensive outpatient or partial hospitalization, outpatient, and emergency department) during the measurement year x 1,000 - Denominator: total number of unique enrollees in the same year	- NCQA HEDIS® (2017-2030)	- National/regional benchmarks	- One group pretest-posttest - Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Subsidiary RQ 2.1.a.iv: Has the implementation of TennCare III maintained or improved utilization of outpatient prescription drugs?	- Per member per month number of outpatient prescriptions for members utilizing prescription services	- Numerator: Total number of outpatient prescriptions for members utilizing prescription services - Denominator: Member months	- Pharmacy Claims Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Per member per month number of outpatient prescriptions filled per month	- Numerator: Total number of outpatient prescriptions filled per month - Denominator: Member months				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 2.2 – Following implementation of the TennCare III demonstration, access to comprehensive primary care will maintain or increase.						
Primary RQ 2.2.a: Has the implementation of TennCare III maintained or increased the number and proportion of TennCare enrollees cared for through the PCMH model?	- Total number of unique TennCare enrollees in PCMHs	- Total number of unique TennCare enrollees in PCMHs	- TennCare PCMH Enrollment Data (2017-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Proportion of TennCare enrollees in a PCMH	- Numerator: number of unique enrollees receiving PCMH care - Denominator: total number of enrollees				
Hypothesis 2.3 – Following implementation of the TennCare III demonstration, member engagement in prenatal and postpartum care will maintain or increase.						
Primary RQ 2.3.a: Has the implementation of TennCare III maintained or increased member engagement in prenatal care?	- Timeliness of Prenatal Care	- Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization[18]	- NCQA HEDIS® (2017-2030)	- National / regional benchmarks	- Difference-in-differences - Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.3.b: Has the implementation of TennCare III maintained or increased member engagement in postpartum care?	- Postpartum Care	- Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery[19]	- TennCare Enrollee Data (2017-2030) - TennCare Claims Data (2017-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Contraceptive Care Postpartum: Women Ages 15-20	**Rate 1** - Numerator: number of women ages 15-20 who had a live birth and were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery - Denominator: number of women ages 15-20 who had a live birth in the measurement year **Rate 2** - Numerator: number of women ages 15-20 who had a live birth and were provided a				

[18] The independent evaluator will adhere to the detailed HEDIS® specifications for this measure.
[19] The independent evaluator will adhere to the detailed HEDIS® specifications for this measure.

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
		long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery				
	- Contraceptive Care Postpartum: Women Ages 21-44	**Rate 1** - Numerator: number of women ages 21-44 who had a live birth and were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery - Denominator: number of women ages 21-44 who had a live birth in the measurement year **Rate 2** - Numerator: number of women ages 21-44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery				- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Screening for Postpartum Depression and Follow-Up Plan: Ages 18 and older	- Numerator: Number of enrollees, ages 18 and older, screened for postpartum depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow up plan is documented on the date of the eligible encounter - Denominator: number of enrollees aged 18 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period				- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Subsidiary RQ 2.3.b.i: Has the implementation of TennCare III increased the months of continuous coverage for postpartum women?	- Months of continuous coverage	- Numerator: number of postpartum women continuously enrolled in TennCare for 12 months after delivery - Denominator: total number of individuals in TennCare that gave birth in the corresponding year	- TennCare Eligibility and Enrollment Data (2019-2030)	- Not applicable	- One-group pretest-posttest	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Subsidiary RQ 2.3.b.ii: Has the implementation of TennCare III increased the use of lactation consultation services among postpartum women?	- Lactation consultation utilization	- Numerator: number of deliveries in which lactation consultation occurred in the 12 months after delivery - Denominator: total number of individuals in TennCare that gave birth in the corresponding year	- TennCare Claims and Encounter Data (2019-2030)	- Not applicable	- Interrupted time series design	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Hypothesis 2.4 – Following implementation of the TennCare III demonstration, MCOs will encourage and/or facilitate the identification of non-medical needs affecting enrollees' health and the referral of enrollees to resources.						

Primary RQ 2.4.a: What strategies did the MCOs implement to address non-medical needs affecting enrollees' health?	- MCOs' strategies related to non-medical needs affecting enrollees' health, such as:
	  - Food insecurity
	  - Transportation
	  - Housing instability
	- Other domains of non-medical needs affecting enrollees' health
		- Not applicable	- MCO Interviews (2023, 2026, 2029)	- Not applicable	- Qualitative analysis	- First Interim Evaluation (2023)
						- Second Interim Evaluation (2026)
						- Third Interim Evaluation (2029)
						- Summative Evaluation (2032)

Primary RQ 2.4.b: Has the percentage of enrollees screened for non-medical needs affecting enrollees' health increased following the implementation of TennCare III?	- Percentage of members that were screened by the MCO for social determinants of health during the reporting period	- Numerator: number of enrollees that were screened by the MCO for social determinants of health, during the reporting period - Denominator: all unique enrollees	- MCO Population Health Data (2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Primary RQ 2.4.c: Has the percentage of enrollees referred to resources to address non-medical needs affecting enrollees' health increased following the implementation of TennCare III?	- Percentage of members that were referred to source(s) to address the social determinants of health screened for	- Numerator: number of members that were referred to source(s) to address the social determinants of health screened for; includes referrals made by the MCO but not referrals made by the provider - Denominator: all unique members that were screened by the MCO for social determinants of health, with an identified social determinant of health need, during the reporting period	- MCO Population Health Data (2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Hypothesis 2.5 – Following implementation of the TennCare III demonstration, participant engagement in dental services for eligible TennCare III enrollees will maintain or increase.						
Primary RQ 2.5.a: Has participant engagement in dental services for TennCare children and adolescents maintained or increased following implementation of TennCare III?	- Partial Enrollment Adjusted Ratio (PEAR)	- Numerator: sum of the full-time equivalent (FTE) for qualifying eligibles with 1 or more qualifying services in the MY - Denominator: sum of FTE for all qualifying eligible - FTE equals the number of days eligible divided by 365.25	- DBM Claims Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- DBM dental sealant rate	- Numerator: number of unduplicated enrollees receiving qualifying dental sealant service in the MY on at least one of the following teeth: 2, 3, 14, 15, 18, 19, 30, 31 - Denominator: number of unduplicated sealant-eligible population	- DBM Claims Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- DBM silver diamine fluoride (SDF) rate	- Numerator: number of unduplicated enrollees receiving qualifying SDF service in the MY on a primary or permanent tooth - Denominator: number of unduplicated eligible population	- DBM Claims Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Primary RQ 2.5.b: Has participant engagement in dental services for pregnant TennCare enrollees maintained or increased following implementation of TennCare III?	- Number of pregnant TennCare enrollees over 21 utilizing dental services during the perinatal period	- Number of pregnant TennCare enrollees over 21 utilizing dental services during the perinatal period	- DBM Claims Data (2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.5.c: Has participant engagement in dental services for postpartum TennCare enrollees increased following implementation of TennCare III?	- Number of postpartum TennCare enrollees over 21 utilizing dental services during the 12 months after delivery	- Number of postpartum TennCare enrollees over 21 utilizing dental services during the 12 months after delivery	- DBM Claims Data (2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.5.d: Has participant engagement in dental services for adult TennCare enrollees increased following implementation of TennCare III?	- Number of TennCare enrollees over 21 utilizing dental services	- Number of postpartum TennCare enrollees over 21 utilizing dental services	- DBM Claims Data (2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Hypothesis 2.6 – Under TennCare III, enrollees will receive Medicaid benefits in excess of those available under the Medicaid State Plan.						
Primary RQ 2.6.a: What benefits did TennCare enrollees receive that were in excess of the benefits authorized under the Medicaid State Plan following implementation of TennCare III?	- Description of benefits and coverage in excess of benefits under Medicaid State Plan	- Not applicable	- TennCare Medicaid Rules (2022-2030) - TennCare Benefit Packages (2022-2030)	- Not applicable	- Qualitative analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Hypothesis 2.7 – DSIPs will continue to provide important services to Tennesseans and expand the provision of health-related services.						
Primary RQ 2.7.a: What is the amount expended on DSIPs under the demonstration?	- DSIP expenditures	- Not applicable	- State Administrative Data (2022-2030)	- Not applicable	- Descriptive analysis	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Primary RQ 2.7.b: What additional services and populations served have occurred as a result of freeing up state funds that would otherwise have been used for DSIPs?	- Description of additional services and populations served as a result of freeing up state funds that would otherwise have been used for DSIPs	- Not applicable	- TennCare Medicaid Rules (2022-2030) - TennCare Benefit Packages (2022-2030)	- Not applicable	- Qualitative analysis	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.7.c: How much has the State invested in other health-related programs as a result of freeing up state funds that would otherwise have been used for DSIPs?	- Amount of dollars invested in other health-related programs as a result of freeing up state funds that would otherwise have been used for DSIPs	- Dollars associated with additional services, programs, and populations served as a result of freeing up state funds that would otherwise have been used for DSIPs	- State Administrative Data (2023-2030)	- Not applicable	- Descriptive analysis	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Hypothesis 2.8 – Following implementation of the TennCare III demonstration, TennCare's UC pools will maintain or increase TennCare enrollee access to eligible safety net providers.						
Primary RQ 2.8.a: Have TennCare's UC pools maintained or increased access to care for TennCare enrollees served by eligible safety net providers?	- Number of TennCare enrollees receiving services from providers receiving UC pool funding	- Number of TennCare enrollees receiving services from providers receiving UC pool funding	- Tennessee Uncompensated Care Data (2017-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.8.b: How has the implementation of TennCare III impacted UC costs?	- Amount of TennCare UC costs[20]	- Sum of total Medicaid UC costs and total uninsured UC costs for DSH and non-DSH CPE hospitals	- Tennessee Uncompensated Care Data (2017-2030)	- Not applicable	- One-group pretest-posttest	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

[20] Since the exact total of TennCare uncompensated costs and claims is currently unavailable in State data sources, the independent evaluator will need to approximate the uncompensated costs using the DSH audit and non-DSH CPE audit data.

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 2.9 – The retroactive eligibility waiver will not significantly impact the likelihood of enrollment, health status of enrollees, or have an adverse financial impact.						
Primary RQ 2.9.a: Do Medicaid-eligible individuals in Tennessee subject to the retroactive eligibility waiver enroll in Medicaid at the same rates as eligible individuals in other states who have access to retroactive eligibility?	- Percentage of Medicaid enrollees by eligibility group out of estimated eligible Medicaid recipients	- Numerator: total number of Medicaid enrollees subject to the retroactive eligibility waiver - Denominator: estimated number of Medicaid-eligible individuals that would be subject to the retroactive eligibility waiver	- TennCare Eligibility and Enrollment Data (2017-2030) - Integrated Public Use Microdata Series American Community Survey (2017-2030)	- Similar adults in other states that provide retroactive coverage	- Difference-in-differences	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.9.b: Does the retroactive eligibility waiver significantly impact likelihood of enrollment continuity for enrollees?	- Percentage of Medicaid enrollees subject to the retroactive eligibility waiver that complete the redetermination process	- Numerator: total number of Medicaid enrollees subject to retroactive eligibility waiver that complete redetermination process - Denominator: total number of Medicaid enrollees subject to retroactive eligibility waiver	- TennCare Eligibility and Enrollment Data (2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.9.c: Do the health outcomes of enrollees subject to the retroactive eligibility waiver differ from those of enrollees in other states who have access to retroactive eligibility?	- Reported excellent or very good health status; healthy days	- BRFSS variables: GENHLTH, MENTHLTH, PHYSHLT, POORHLTH	- Behavioral Risk Factor Surveillance System (BRFSS) (2017-2030)	- Similar adults in other states that provide retroactive coverage	- Difference-in-differences	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.9.d: What are common barriers to timely renewal for enrollees subject to the retroactive eligibility waiver?	- Reported barriers to timely renewal	- Not applicable	- TennCare Enrollee Survey (2023, 2025, 2027, 2029)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Primary RQ 2.9.e: Do Medicaid eligible individuals in Tennessee subject to the waiver of retroactive eligibility experience greater 'medical debt' relative to members in the program who are exempt from the waiver?	- Whether enrollee reports medical debt - If yes, amount of medical debt reported	- Not applicable	- TennCare Enrollee Survey (2025, 2027, 2029) – one survey for enrollees subject to retroactive eligibility waiver and one survey for comparison group	- Control group of similar adults not subject to the retroactive eligibility waiver	- Comparison of means	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 2.9.f: Are Medicaid eligible individuals in need of acute care able to enroll in TennCare quickly?	- Number of individuals presenting at hospitals presumptively determined eligible for and enrolled in Medicaid	- Not applicable	- TennCare Eligibility and Enrollment Data (2022-2030)	- Not applicable	- Descriptive analysis	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Hypothesis 2.10 – Rates of adoption for children in state custody will increase when Medicaid coverage is available for all children.						
Primary RQ 2.10.a: Has the implementation of TennCare III (and resulting extension of TennCare coverage to children adopted from state custody) increased the number and percentage of children adopted from state custody?	- Number of children adopted from state custody - Percentage of children adopted from state custody	- Not applicable	- State Administrative Data (2017-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Figure 16. Analytic Table – Goal 3: Ensure enrollees' satisfaction with services

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 3.1 – Following implementation of the TennCare III demonstration, TennCare enrollee satisfaction with health care services will maintain or improve.						
Primary RQ 3.1.a: Has the implementation of TennCare III maintained or improved TennCare enrollee satisfaction with overall health care?	- Percent of Respondents Indicating Satisfaction with TennCare	- Numerator: number of respondents indicating they are "very satisfied" or "somewhat satisfied" with the TennCare program - Denominator: total number of survey respondents	- Beneficiary Satisfaction Survey (2011-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 3.1.b: Has the implementation of TennCare III maintained or improved CHOICES enrollee satisfaction?	- Percentage of people whose paid support staff do things the way they want them done	- Numerator: number of respondents who reported paid support staff do things the way they want them done (Response Options: No/Never/Rarely, Some/Usually, Yes/Always/Almost Always, Don't Know, Unclear/Refused/No Response) - Denominator: total number of respondents	- NCI-AD Survey (MY 2016-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Percentage of people whose long-term care services meet all their current needs and goals	- Numerator: number of respondents who reported long-term care services meet all their current needs and goals (Response Options: No/Not at All, Some Needs and Goals, Yes/Completely/All Needs and Goals, Don't Know, Unclear/Refused/No Response) - Denominator: total number of respondents				
Primary RQ 3.1.c: Has the implementation of TennCare III maintained or improved satisfaction of individuals with I/DD?	- Percentage of people who report they realized personal goals (POM 21)	- Numerator: number of respondents who accomplish goals significant to them - Denominator: total number of survey respondents who provided valid answers to the survey question	- CQL POMs Survey (MY 2025-2030)	- Respondents to CQL POMs Survey in other states	- Descriptive analysis followed by difference-in-differences in later years	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Percentage of people who report they participate in the life of the community (POM 11)	- Numerator: number of respondents who participate in the life of the community, with the type and frequency of participation they prefer - Denominator: total number of survey respondents who provided valid answers to				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
		the survey question				
Primary RQ 3.1.d: Are parents of children enrolled in the Katie Beckett program satisfied with the services provided through the program?	- Percentage of family respondents who report being satisfied overall with the services and supports their family currently receives	- Numerator: number of family respondents who reported being satisfied overall with the services and supports their family currently receives (Response Options: Always, Usually, Sometimes, Seldom or Never) - Denominator: total number of family respondents	- NCI Child Family Survey (MY 2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Figure 17. Analytic Table – Goal 4: Provide enrollees with appropriate and cost-effective HCBS within acceptable budgetary parameters

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 4.1 – Following implementation of the TennCare III demonstration, the proportion of individuals who receive HCBS rather than NF care will maintain or increase.						
Primary RQ 4.1.a: Has the implementation of TennCare III maintained or increased the number and percentage of CHOICES enrollees actively receiving HCBS?	- Number and percentage of CHOICES enrollees actively receiving HCBS at a point-in-time, by benefit group	- Numerator: number of CHOICES enrollees actively receiving HCBS at the end of each demonstration month - Denominator: total number of CHOICES enrollees at the end of each demonstration month	- TennCare Claims and Encounter Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Aggregate number and percentage of CHOICES enrollees actively receiving HCBS, by benefit group	- Numerator: unduplicated number of CHOICES enrollees receiving HCBS over a 1-month period - Denominator: unduplicated number of CHOICES enrollees over the same 1-month period				
	- Number and percentage of CHOICES enrollees actively receiving NF services at a point-in-time, by benefit group	- Numerator: number of CHOICES enrollees actively receiving NF at the end of each demonstration month - Denominator: total number of CHOICES enrollees at the end of each demonstration month				
	- Aggregate number and percentage of CHOICES enrollees actively	- Numerator: unduplicated number of CHOICES enrollees receiving NF over a 1-month period - Denominator: unduplicated number of				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
	receiving NF services, by benefit group	CHOICES enrollees over the same 1-month period				
Primary RQ 4.1.b: Has the implementation of TennCare III maintained or increased the ratio of HCBS to NF service costs for CHOICES enrollees?	- Monthly HCBS service costs for CHOICES enrollees	- Based on encounters and not cap payments	- TennCare Claims and Encounter Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- HCBS service costs for CHOICES enrollees as a percentage of total long-term care service costs	- Numerator: total monthly HCBS service costs for CHOICES enrollees - Denominator: total monthly LTSS service costs (HCBS and NF) for CHOICES enrollees				
	- Monthly NF service costs for CHOICES enrollees	- Based on encounters and not cap payments				
	- NF service costs for CHOICES enrollees as a percentage of total long-term care service costs	- Numerator: total monthly NF service costs for CHOICES enrollees - Denominator: total monthly LTSS service costs (HCBS and NF) for CHOICES enrollees				
Primary RQ 4.1.c: Has the implementation of TennCare III maintained or decreased the average LTSS costs per CHOICES enrollee?	- Average monthly HCBS service costs per CHOICES enrollee	- Based on encounters and not cap payments	- TennCare Claims and Encounter Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Average monthly NF service costs per CHOICES enrollee	- Based on encounters and not cap payments				
Primary RQ 4.1.d: Has the implementation of TennCare III maintained or increased the number and percentage of individuals with I/DD actively receiving HCBS?	- Number and percentage of individuals with I/DD actively receiving HCBS at a point-in-time, by benefit group	- Numerator: number of individuals with I/DD actively receiving HCBS at the end of each demonstration month - Denominator: total number of individuals with I/DD at the end of each demonstration month	- TennCare Claims and Encounter Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Aggregate number and percentage of individuals with I/DD	- Numerator: unduplicated number of individuals with I/DD receiving HCBS over a 1-month period - Denominator: unduplicated number of				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
	actively receiving HCBS, by benefit group	individuals with I/DD over the same 1-month period				
Primary RQ 4.1.e: Has the implementation of TennCare III maintained or increased the ratio of HCBS to ICF/IID service costs for individuals with I/DD?	- Monthly HCBS service costs for individuals with I/DD	- Based on encounters and fee-for-service expenditures, not capitation payments	- TennCare Claims and Encounter Data (2017-2030)	- Not applicable	- Interrupted time series	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- HCBS service costs for individuals with I/DD as a percentage of total long-term care service costs	- Numerator: total HCBS service costs for individuals with I/DD monthly - Denominator: total LTSS service costs (HCBS and ICF/IID) for individuals with I/DD monthly - Based on encounters and fee-for-service expenditures, not capitation payments				
	- Monthly ICF/IID service costs	- Based on encounters and fee-for-service expenditures, not capitation payments				
	- ICF/IID service costs as percentage of total LTSS service costs for individuals with I/DD	- Numerator: total ICF/IID service costs for individuals with I/DD monthly - Denominator: total LTSS service costs (HCBS and ICF/IID) for individuals with I/DD monthly - Based on encounters and fee-for-service expenditures, not capitation payments				
Primary RQ 4.1.f: Has implementation of the TennCare III demonstration maintained or decreased the average LTSS costs per individual with I/DD?	- Average HCBS service costs per individual with I/DD	- Based on encounters and fee-for-service expenditures, not capitation payments	- TennCare Claims and Encounter Data (2017-2030)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Average ICF/IID service costs per individual with I/DD	- Based on encounters and fee-for-service expenditures, not capitation payments				
Primary RQ 4.1.g: Has the implementation of TennCare III maintained or increased the level of institutional transition and diversion for CHOICES enrollees?	- Institutional diversion – CHOICES enrollees who meet NF level of care but access HCBS as an alternative	- Numerator: Number of CHOICES enrollees annually who meet level of care for NF but access HCBS for a minimum of 90 days - Denominator: total number of unique CHOICES enrollees annually	- TennCare Claims and Encounter Data (2017-2030)	- Not applicable	- One group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation
	- Institutional transition – number of CHOICES	- Number of CHOICES enrollees who use transition services to move from NFs to	- TennCare Claims and Encounter Data	- Not applicable	- Interrupted time series	

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
	enrollees who transition from NFs to HCBS monthly	HCBS monthly	(2017-2030)			(2032)
	- Diversion – NF diversion rate	- Numerator: number of individuals applying for NF care but diverted to HCBS monthly - Denominator: total number of individuals applying to NF care monthly	- TennCare Claims and Encounter Data (2012030)	- Not applicable	- Interrupted time series	
	- Diversion – average CHOICES enrollee length of stay in HCBS monthly	- Numerator: total length of stay in HCBS for all unique CHOICES enrollees monthly - Denominator: total number of unique CHOICES enrollees monthly	- TennCare Claims and Encounter Data (2012030)	- Not applicable	- Interrupted time series	
	- Diversion – percent of new LTSS recipients admitted to NFs monthly	- Numerator: number of new LTSS recipients in CHOICES admitted to NFs monthly - Denominator: number of new LTSS recipients in CHOICES				
Hypothesis 4.2 – Following implementation of the TennCare III demonstration, participation levels in integrated employment for individuals with I/DD will maintain or increase.						
Primary RQ 4.2.a: Has the implementation of TennCare III maintained or increased the number of individuals with I/DD that participate in integrated employment and earn at or above the minimum wage?	- Number of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage	- Number of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage	- TennCare Individual Employment Data Survey (2017-2030)	- Not applicable	- One-group pretest-posttest	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Percentage of working age adults with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage	- Numerator: number of individuals (22-62) with I/DD enrolled in HCBS programs who are employed in an integrated setting earning at or above the minimum wage as reported in the Individual EDS annually - Denominator: Total number of individuals with I/DD enrolled in HCBS programs annually				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 4.3 – The integration of existing HCBS waivers into managed care will maintain or improve the ability for individuals with I/DD to choose services.						
Primary RQ 4.3.a: Has the integration of existing HCBS waivers into managed care maintained or improved the ability for individuals with I/DD to choose services?	- Percentage of people who report choosing services	- Numerator: number of respondents who choose the services/supports they receive, their provider organizations, and their direct support professionals/staff - Denominator: total number of survey respondents who provided valid answers to the survey question	- CQL POMs Survey (MY 2025-2030)	- Respondents to CQL POMs Survey in other states	- Descriptive analysis followed by difference-in-differences in later years	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Hypothesis 4.4 – Following enrollment in the Katie Beckett program, access to care for children eligible for Parts A and B of the Katie Beckett program will maintain or improve.						
Primary RQ 4.4.a: Has enrollment in the Katie Beckett program maintained or improved access to care for eligible children?	- Percentage of family respondents who report they are able to contact their child's case manager when they want	- Numerator: number of family respondents who report they are able to contact their child's case manager when they want (Response Options: Always, Usually, Sometimes, Seldom or Never) - Denominator: total number of respondents	- NCI Child Family Survey (MY 2022-2030)	- Not applicable	- One-group posttest-only	- Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Percentage of family respondents who report that their child has the special equipment or accommodations that s/he needs	- Numerator: number of family respondents who reported that their child has the special equipment or accommodations that s/he needs (Response Options: Always, Usually, Sometimes, Seldom or Never) - Denominator: total number of respondents				
	- Percentage of family respondents who report that their child can see health professionals when needed	- Numerator: number of family respondents who reported that their child can see health professionals when needed (Response Options: Always, Usually, Sometimes, Seldom or Never) - Denominator: total number of respondents				
	- Percentage of family respondents who report that their child can go to the dentist when needed	- Numerator: number of family respondents who report that their child can go to the dentist when needed (Response Options: Always, Usually, Sometimes, Seldom or Never) - Denominator: total number of respondents				

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
	- Percentage of family respondents who report that they are able to get respite services if they need them	- Numerator: number of family respondents who report that they are able to get respite services if they need them (Response Options: Always, Usually, Sometimes, Seldom or Never) - Denominator: total number of respondents				
	- Percentage of family respondents who report that their family gets the supports and services it needs	- Numerator: number of family respondents who report that their family gets the supports and services it needs (Response Options: Yes, No) - Denominator: total number of respondents				
Hypothesis 4.5 – Following implementation of the TennCare III demonstration, premium requirements for participants in Part A of the Katie Beckett program will not reduce the likelihood of enrollment or enrollment continuity among participants.						
Primary RQ 4.5.a: How many and what percentage of children approved for Part A of the Katie Beckett program do not enroll due to non-payment of the premium?	- Number and percentage of children approved for Part A of the Katie Beckett program who do not enroll due to non-payment of premium	- Numerator: number of children approved for Part A of Katie Beckett program who do not enroll due to non-payment of premium - Denominator: total number of children approved for Part A	- TennCare Eligibility and Enrollment Data (2022-2030)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 4.5.b: How many and what percentage of Katie Beckett Part A program enrollees are suspended from the program due to non-payment of premiums?	- Number and percentage of individuals who are suspended from Part A of the Katie Beckett program due to non-payment of premiums	- Numerator: number of children suspended from Part A of Katie Beckett program due to non-payment of premium - Denominator: total number of children enrolled in Part A annually	- TennCare Eligibility and Enrollment Data (2022-2030)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Primary RQ 4.5.c: How many and what percentage of Katie Beckett Part A program enrollees voluntarily separate from the program?	- Number of individuals who voluntarily separate from Part A of the Katie Beckett program	- Number of individuals who voluntarily separate from Part A of the Katie Beckett program	- TennCare Eligibility and Enrollment Data (2022-2030)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Subsidiary RQ 4.5.c.i: Among Katie Beckett Part A program enrollees who voluntarily separate from the program, to what extent is this voluntary separation associated with the premium requirements?	- Reasons for voluntary separation from Part A of the Katie Beckett program	- Not applicable	- TennCare Enrollee Survey or Focus Group (2023, 2026, 2029)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 4.5.d: What is the health insurance status and reported change in health status among Katie Beckett Part A enrollees that were: • Suspended from the program due to non-payment of premiums; or • Voluntarily separated from the program?	See subsidiary questions below.	See subsidiary questions below.	See subsidiary questions below.	See subsidiary questions below.	See subsidiary questions below.	See subsidiary questions below.
Subsidiary RQ 4.5.d.i: What is the health insurance status and reported change in health status among Katie Beckett Part A enrollees that were suspended from the program due to non-payment of premiums?	- Insurance status for Katie Beckett Part A enrollees who were suspended	- Not applicable	- TennCare Enrollee Survey or Focus Group (2023, 2026, 2029)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Reported health status for Katie Beckett Part A enrollees who were suspended		- TennCare Enrollee Survey or Focus Group (2023, 2026, 2029)	- Enrollees who remain in Tennessee's Katie Beckett program	- Comparison of means	

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Subsidiary RQ 4.5.d.ii: What is the health insurance status and reported change in health status among Katie Beckett Part A enrollees that voluntarily separated from the program?	- Insurance status for Katie Beckett Part A enrollees who voluntarily separated	- Not applicable	- TennCare Enrollee Survey or Focus Group (2023, 2026, 2029)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Reported health status for Katie Beckett Part A enrollees who voluntarily separated		- TennCare Enrollee Survey or Focus Group (2023, 2026, 2029)	- Enrollees who remain in Tennessee's Katie Beckett program	- Comparison of means	
Hypothesis 4.6 – Part B of the Katie Beckett program (Medicaid Diversion) will delay and/or divert eligible children from enrolling in TennCare.						
Primary RQ 4.6.a: Has the implementation of Part B of the Katie Beckett program delayed and/or diverted eligible children from enrolling in TennCare?	- Length of stay in Katie Beckett for Part B enrollees who meet the at-risk level of care - percentage	- Numerator: number of days in Katie Beckett Part B program for enrollees who meet the at-risk level of care - Denominator: number of days between enrollment and age-out of Katie Beckett program (at age 18) for enrollees who meet the at-risk level of care	- TennCare Eligibility and Enrollment Data (2021-2030)	- Not applicable	- One-group posttest-only	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
	- Imputed savings of Katie Beckett Part B enrollees who meet the at-risk level of care	- Estimated cost of Part B enrollees who meet the at-risk level of care if enrolled in full TennCare benefits, minus the $10,000 Part B per enrollee funding cap				

Figure 18. Analytic Table – Goal 5: 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

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Hypothesis 5.1 – Following implementation of the TennCare III demonstration, TennCare expenditures will grow at a slower and more sustainable rate than the average national Medicaid expenditures.						
Primary RQ 5.1.a: Has TennCare maintained an expenditure growth rate that is slower than the average national Medicaid expenditure growth rate?[21]	- Total TennCare expenditure growth rate	- Numerator: TennCare expenditures from the previous year subtracted from TennCare expenditures in the current year - Denominator: TennCare expenditures from the previous year	- TennCare Expenditure Data (2017-2030) - Medicaid Budget and Expenditure System (MBES) (2017-2030)	- National benchmarks	- Difference-in-differences	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)

[21] The independent evaluator will consider impacts of the American Rescue Plan, including enhanced Federal Medical Assistance Percentages (FMAP) funds.

Research Question	Outcome Measure(s)	Specifications	Data Source(s)	Comparison Group	Analytic Approach	Reporting Schedule
Primary RQ 5.1.b: What is the difference between TennCare's aggregate costs by expenditure group compared to the budget neutrality test limits by expenditure group and how does this change over the duration of the demonstration period?	- TennCare aggregate costs by expenditure group vs. budget neutrality test limits by expenditure group	- Total annual TennCare aggregate costs across expenditure groups subtracted from total annual budget neutrality test limits across expenditure groups	- TennCare Expenditure Data (2021-2030)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Primary RQ 5.1.c: What are the administrative operational costs of the demonstration?	- Administrative cost of ongoing demonstration operation	- Administrative cost of ongoing demonstration operation	- TennCare Expenditure Data (2021-2030)	- Not applicable	- Descriptive analysis	- First Interim Evaluation (2023) - Second Interim Evaluation (2026) - Third Interim Evaluation (2029) - Summative Evaluation (2032)
Hypothesis 5.2 – Following the implementation of TennCare's authority to suspend Medicaid eligibility for enrollees who have been convicted of Medicaid fraud, the number of Medicaid fraud incidents in State or Local courts will maintain or decrease.						
Primary RQ 5.2.a: Has the implementation of TennCare's authority to suspend Medicaid eligibility for individuals convicted of Medicaid fraud maintained or decreased the number of enrollees who have been convicted of Medicaid fraud in State or Local courts?	- Number of enrollees convicted of Medicaid fraud in State or Local courts	- Number of enrollees convicted of Medicaid fraud in State or Local courts	- State and Local Law Enforcement Agency Data (TBD, when authority is implemented)	- Not applicable	- Interrupted time series design	- TBD, when authority is implemented
Primary RQ 5.2.b: What is the reported health insurance status among individuals who are suspended from TennCare due to a Medicaid fraud conviction?	- Insurance status of suspended individuals before and after conviction	- Not applicable	- TennCare Administrative Data (TBD, when authority is implemented)	- Not applicable	- Descriptive analysis	- TBD, when authority is implemented

D. Methodological Limitations

Section D details the methodological limitations of the TennCare III Evaluation Design, how said limitations may prevent causal inferences about the impact of TennCare III program components, and what approaches may be taken by the independent evaluator to minimize these limitations.

Figure 19 details overarching limitations that impact all demonstration goals. **Figure 20** provides a detailed breakdown of methodological limitations specific to demonstration goals.

Figure 19. Methodological Limitations – Overall

Limitation	Description of Limitation	Approaches to Minimizing Limitation
COVID-19 impact	• Beginning in March 2020, the COVID-19 pandemic spurred significant changes in health care service delivery and utilization. The public health emergency will likely alter Medicaid enrollment levels, program expenditures, enrollee satisfaction, service utilization, and access to care. • COVID-19 has prevented standard data collection for multiple measures, including the NCI and NCI-AD Surveys, which involve in-person interviews. Since in-person interviews were infeasible in MY 2020-2021, NCI and NCI-AD data were not collected for this time period.	• CYs 2020 and 2021 were largely removed from the analytic method baseline and intervention evaluation periods. • The inclusion of any data from CYs 2020 and 2021 will be carefully analyzed by the independent evaluator and supplemented by data from additional pre-COVID-19 or post-COVID-19 years. Utilization data from these years will be particularly scrutinized and/or avoided due to COVID-19-related impacts. • For questions related to TennCare program expenditures and the budget neutrality test limits (e.g., 5.1.a and 5.1.b), the independent evaluator will consider impacts of the American Rescue Plan, including enhanced Federal Medical Assistance Percentages (FMAP) funds. • In the evaluation reports, the independent evaluator will also recognize and account for additional funding and potential increases in payments to NFs because of COVID-19, which could affect LTSS cost trends.
Limited number of in-state comparison groups	• Since many of the TennCare III demonstration components impact the entire TennCare enrollee population, in-state comparison groups are largely infeasible. For demonstration components that target specific subgroups, such as the Katie Beckett program, the unique characteristics of the target population (e.g., children under the age of 18 with complex medical needs or disabilities) also limit the availability of appropriate in-state comparison groups. The inability to identify in-state comparison groups	• The Evaluation Design includes out-of-state comparisons wherever possible. Out-of-state comparison groups will be selected for similarity to the TennCare intervention population, including using propensity score matching to select a similar cohort for the comparison group whenever possible. • The Evaluation Design includes comparisons to national and regional benchmarks, which can provide a valid counterfactual, or an approximation of the intervention group had they not been exposed to the intervention.

Limitation	Description of Limitation	Approaches to Minimizing Limitation
	could render certain outcomes at least partly attributable to extraneous factors outside of the demonstration.	However, these benchmarks assume that TennCare enrollees are similar to Medicaid enrollees either nationally or in the chosen regions.
Limited ability to control for differences in Medicaid populations in other states	• Medicaid population demographics and other characteristics vary greatly among states. As a result, when using data sources like ACS for out-of-state comparison groups, the independent evaluator may have limited ability to control for different characteristics.	• The independent evaluator can select out-of-state comparison groups from states with similar Medicaid eligibility requirements, geographic variation, and income levels. • The independent evaluator may use statistical techniques (e.g., propensity score matching) to control for differences, when necessary.
Limitations of ITS and one-group pretest-posttest analyses	• ITS requires data for the same time period length before and after the implementation of treatment. This disqualifies certain data sources that do not provide a sufficient volume of historical data from being included in the later Interim and Summative Evaluations, given the 10-year length of the TennCare III demonstration. • Since ITS and pretest-posttest are intended to be longitudinal methods of analysis, they become unsuitable when characteristics of the intervention population and/or economic environment change over time. There may be certain changes that the independent evaluator cannot control for.	• ITS will mainly be used for data sources where a sufficient amount of pre-implementation historical data is available. • Population differences over time will be observed. If necessary, matching techniques can be used to address the differences.
Confounding factor: changes in case-mix over time	• The TennCare population may change and fluctuate in terms of eligibility, enrollee demographics, service utilization, medical needs, and other demographic characteristics throughout the 10-year demonstration period.	• It is intended for the independent evaluator to report on appropriate caveats, context, and discussion of data limitations related to the TennCare enrollee population.
Limitations in survey data collection	• Survey length could affect the response rate. • A lower response rate will have a negative impact on the representativeness and generalizability of the survey data. • New surveys created and proposed for the Evaluation must use baseline data that is gathered after the actual demonstration implementation. • The number of eligible participants or response rate for surveys targeting	• The independent evaluator will ensure that surveys do not exceed a reasonable amount of time to complete (e.g., 15 minutes). • Appropriate caveats, context, and discussion of data limitations on response rate and sample size will be included in the Evaluation Reports. • The surveys will contain retrospective questions about enrollee outcomes and perspectives of the demonstration implementation and the years leading up

Limitation	Description of Limitation	Approaches to Minimizing Limitation
	individuals not actively enrolled in the Katie Beckett program may be low.	to implementation where applicable. • The independent evaluator will take efforts (e.g., follow up with individuals until the target sample size is met) to meet the minimum threshold required for inclusion and use sample weighting or other techniques to ensure a fully representative sample. • Appropriate caveats, context, and discussion of data limitations will be included in the Evaluation Reports.
Limitations in isolating the effects of overlapping demonstration components	• It may be difficult to establish a causal relationship between a singular demonstration component and a demonstration outcome. Since many TennCare III program components impact the entire TennCare population, multiple components may be contributing to a certain outcome in the intervention population.	• Regression analysis may be used to control for confounding factors where appropriate. • Sufficient qualitative analysis and interpretation of quantitative results will provide context for any potential overlap in outcomes. • Staggered implementation of program components not yet implemented (e.g., fraud suspension) may be considered to help isolate the effects on TennCare's demonstration goals.
Limitation of DiD analysis	• DiD is most effective when beneficiary-level data is available. However, there may be measures for which beneficiary-level out-of-state data is unavailable, and national or regional benchmarks must be used (e.g., HEDIS® measures). Since the benchmarks are set at an aggregate level (program- or plan-wide), the statistical power of the DiD approach and out-of-state comparison is limited. • To support a causal interpretation, DiD requires the assumption of "parallel trends" of the intervention and comparison groups, meaning that if the intervention was not implemented, the change in the intervention group would be the same as the change in the comparison group. This assumption may be challenged by the lack of a viable in-state comparison group.	• Comparison to benchmarks offers a higher level of rigor than if there was no comparison group whatsoever. • Comparison to benchmarks will be supplemented with descriptive analysis, comparison to historical data, and additional context where possible. • The independent evaluator may use techniques such as visual trend analysis to confirm that the "parallel trend" assumption is met with the selected out-of-state comparison group.
Limitation of availability of pre-period data	• For hypotheses and research questions related to policy components that remain unchanged between TennCare II and TennCare III (e.g., CHOICES), it is less likely that a significant change in utilization or other outcomes will be	• The independent evaluator should be specific in their interpretation for these research questions; the results should be interpreted as the change in observed trends between TennCare II and TennCare III, as opposed to interpreting

Limitation	Description of Limitation	Approaches to Minimizing Limitation
	observed between the two demonstrations. Instead, pre-period data (e.g., prior to TennCare I implementation) should be used to address questions about impacts or changes. • The ability to use or access pre-period data from prior to the original TennCare Demonstration is limited or infeasible.	as the effect of the original policy implementation.

Figure 20. Methodological Limitations – Goal-Specific

Limitation	Description of Limitation	Approaches to Minimizing Limitation
Goal 2: Ensure enrollee access to health care, including safety net providers		
Limited ability to isolate the impact of TennCare III on the longstanding retroactive eligibility waiver	• Since the retroactive eligibility waiver has been in place since 1994, it may be difficult to isolate the effect of the waiver specifically under TennCare III. • When comparing to other states, it will be difficult to isolate differences in outcomes due to the impact of the retroactive eligibility waiver, since Medicaid programs vary widely in policies and implementation.	• It is intended that the independent evaluator will include appropriate context regarding retroactive eligibility limitations in the Interim and Summative Evaluations.
Goal 4: Provide enrollees with appropriate and cost-effective HCBS within acceptable budgetary parameters		
Limited ability to isolate the impact of TennCare III on the longstanding CHOICES program and I/DD programs	• Since the CHOICES program has existed since 2010, ECF CHOICES since 2016, and 1915c waiver programs since 1987, it may be difficult to isolate the effect of TennCare III on each MLTSS program.	• Appropriate caveats, context, and discussion of data limitations will be included in the Evaluation Reports.

E. Attachments

1. Independent Evaluator

TennCare has selected Guidehouse as its independent evaluator. Guidehouse has over 20 years of experience analyzing and evaluating health-related programs. Members of the Guidehouse team have backgrounds in health policy, health economics, statistical modeling, survey design, and quantitative and qualitative research methods. A Guidehouse team assisted TennCare with the development of the TennCare III Evaluation Design.

Guidehouse is currently under contract to provide actuarial services to the Tennessee Department of Finance and Administration, Division of TennCare. To ensure an independent evaluation, Guidehouse is establishing a separate team that is primarily responsible for the analyses and evaluation required by the TennCare III Evaluation Design. This team will operate independently of teams involved in actuarial and/or implementation activities. Guidehouse will also sign a “no conflict of interest” statement.

As such, TennCare can assure that Guidehouse will conduct a fair and impartial evaluation, prepare objective Evaluation Reports, and that there will be no conflict of interest.

2. Evaluation Budget

The table below presents a breakdown of estimated evaluation costs by calendar year. While the demonstration is approved for 10 years, the required total evaluation period (inclusive of work after the conclusion of the demonstration) spans 12 calendar years.

Evaluation Budget Estimates

Calendar Year	Estimated Cost
CY 2021	$223,250
CY 2022	$470,000
CY 2023	$1,010,500
CY 2024	$470,000
CY 2025	$470,000
CY 2026	$1,010,500
CY 2027	$470,000
CY 2028	$470,000
CY 2029	$1,010,500
CY 2030	$470,000
CY 2031	$470,000
CY 2032	$558,500
Total Cost (July 2021 - June 2032)	**$7,103,250**

The average evaluation cost is estimated to be roughly $591,938 per calendar year.

Over the life of this required demonstration evaluation period, we estimate that 5 percent ($355,162.50) of the total evaluation budget will be spent on survey and measure development; 15 percent ($1,065,487.50) on qualitative data collection, cleaning, and coding; 40 percent ($2,841,300) on quantitative data collection, cleaning, and coding; and 40 percent ($2,841,300) on analyses and report generation. Funds to support travel to focus groups and interviews and the purchase of software, hardware, and supplies are also included.

3. Timeline and Major Milestones

Figure 21 describes the timeline for hiring an independent evaluator and submitting Evaluation-related deliverables to CMS.

Figure 21. TennCare III Evaluation: Timeline and Major Milestones

Task	CY 2021				CY 2022				CY 2023				CY 2024				CY 2025				CY 2026				CY 2027				CY 2028				CY 2029				CY 2030				CY 2031				CY 2032			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Prepare																																															
Contract with Independent Evaluator																																															
Reporting *(shaded months indicate month of submission)*																																															
Quarterly Monitoring Reports																																															
Annual Monitoring Reports																																															
Interim Evaluation Reports																																															
Summative Evaluation Report																																															

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. 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):

X	**Pandemic or Epidemic**
○	**Natural Disaster**
○	**National Security Emergency**
○	**Environmental**
○	**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.

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:***

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.

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.

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]

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.]

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 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.

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.

[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.]

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

iv ☐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)

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.

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

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.

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 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.

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 kin 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.

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):
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 N
Monitoring Protocol

Overview: The Monitoring Protocol for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Protocol Workbook (Part A) and a Monitoring Protocol Template (Part B). Each state with an approved eligibility and coverage policy in its section 1115 demonstration should complete only one Monitoring Protocol Template (Part B) that encompasses all eligibility and coverage policies approved in its demonstration as well as the demonstration overall, in accordance with the demonstration's special terms and conditions (STCs). This state-specific Part B Template reflects the composition of the eligibility and coverage policies in the state's demonstration. For more information and any questions, the state should contact the CMS section 1115 demonstration team.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here.

1. Title page for the state's eligibility and coverage demonstrations or eligibility and coverage policy components of the broader demonstration

The state should complete this title page as part of its eligibility and coverage monitoring protocol.

This section collects information on the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. This form should be submitted as the title page for all eligibility and coverage monitoring reports. The content of this table should stay consistent over time. All approval periods should include a start date and an end date (MM/DD/YYYY - MM/DD/YYYY). The dates in this section should pertain to the current demonstration period. For a policy that the state implemented as part of a previous demonstration, the state should treat the approval period start date of the current demonstration as the implementation date unless the state has set a new date to implement a modified version of the policy.

Overall section 1115 demonstration	
State	Tennessee
Demonstration name	TennCare III
Approval period for section 1115 demonstration	01/08/2021-12/31/2030
Premiums or account payments	
Premiums or account payments start date	01/08/2021
Implementation date if different from premiums or account payments start date	N/A
Retroactive eligibility waiver	
Retroactive eligibility waiver start date	01/08/2021
Implementation date, if different from retroactive eligibility waiver start date	N/A

Notes:

1. **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at the time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage

demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

2. **Implementation date of policy:** The date of implementation for each eligibility and coverage policy in the state's demonstration.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will report the requested narrative information.

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 eligibility and coverage demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first eligibility and coverage demonstration year (DY) of less than 12 months, should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocol. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first eligibility and coverage DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 eligibility and coverage demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by eligibility and coverage policy). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics

data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing a decrease in beneficiaries who did not pay premiums and were disenrolled from Medicaid (Metric PR_15) over the course of the retrospective reporting period. This state may decide to highlight this change for CMS in Part B of its monitoring report by briefly summarizing the trend and explaining that during this period the state conducted additional outreach to beneficiaries about the renewal process.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval:

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (AD, PR, RW) (Version 3.0)
State Tennessee
Demonstration Name TennCare III

Table: Eligibility and Coverage Demonstration Metrics

Standard information on CMS-provided metrics										Alignment with CMS-provided technical specifications manual	
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.), or other considerations[b,c]
EXAMPLE: AD_1 ***(Do not delete or edit this row)***	*EXAMPLE: Total enrollment in the demonstration*	*EXAMPLE: The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.*	*EXAMPLE: 1.1.1 Enrollment*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: Y*	*EXAMPLE:*
Any Demonstration (AD)											
AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	Y	Y	
AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y	Y	
AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y	Y	
AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y	Y	
AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y	Y	
AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Required	Y	Y	
AD_35	Emergency department utilization, all use	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Required	Y	Y	
AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Required	Y	Y	
BA_7	Plan All-Cause Readmissions (PCR-AD)	For beneficiaries aged 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1.Count of Index Hospital Stays (IHS) 2.Count of Observed 30-Day Readmissions 3.Count of Expected 30-Day Readmissions	n.a.	Claims and encounters	None	Calendar year	Annually	Required	Y	Y	
State-specific metrics											
S1_TN	CHOICES enrollment	Number of beneficiaries enrolled in CHOICES by benefit group	n.a.	Administrative records		Quarter	Quarterly	State-specific	Y		
S2_TN	ECF CHOICES enrollment	Number of beneficiaries enrolled in Employment and Community First CHOICES by benefit group	n.a.	Administrative records		Quarter	Quarterly	State-specific	Y		
S3_TN	Katie Beckett (Part A) enrollment	Number of beneficiaries enrolled in Katie Beckett (Part A)	n.a.	Administrative records		Quarter	Quarterly	State-specific	Y		
S4_TN	Medicaid Diversion (Part B) enrollment	Number of beneficiaries enrolled in Medicaid Diversion (Part B)	n.a.	Administrative records		Quarter	Quarterly	State-specific	Y		
S5_TN	Uncompensated care payments	Amount of dollars paid to providers for uncompensated care through the Virtual DSH Fund and the Charity Care Fund	n.a.	Administrative records		Quarter	Quarterly	State-specific	Y		
Premiums and Account Payments (PR)											
PR_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), regardless of whether they paid or did not pay during the measurement period.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	Y	
PR_3	Beneficiaries who paid a premium during the month	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who paid this month.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	Y	
PR_15	Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid	Number of demonstration beneficiaries disenrolled from Medicaid as of the last day of the measurement period for failure to pay premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has premiums or monthly payment with a policy of termination for failure to pay	Y	Y	
PR_16	Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who were disenrolled from Medicaid for failure to pay premiums and are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, including those prevented from re-enrolling until their redetermination date.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required	Y	N	State plans to report beneficiaries who were disenrolled for non-payment of premiums and cannot re-enroll because of unpaid premiums.
PR_17	Beneficiaries whose benefits are suspended for failure to pay	Number of demonstration beneficiaries whose benefits were suspended during the measurement period for failure to pay premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if the state has premiums or monthly payment with a policy of suspending benefits (without disenrollment) for failure to pay	Y	Y	

#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N/n.a.)	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.), or other considerations[b,c]
Waiver of Retroactive Eligibility (RW)											
RW_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	Percentage of beneficiaries in the demonstration in income and eligibility groups who were subject to the waiver or non-applicability of retroactive eligibility and indicated that they had unpaid medical bills from the three months (or other time period specified by the state) prior to their Medicaid application during the measurement period.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	30 days	Month	Quarterly	Required	Y	N	Captured through a beneficiary survey which will be fielded three times during the 10-year approval period. Question on unpaid medical bills that appears in the beneficiary survey: *[Enter the question on unpaid medical bills that appears in the beneficiary survey]*
RW_2	Beneficiaries who return their renewal form during the reconsideration period	Number of beneficiaries in the demonstration in income and eligibility groups that were subject to the waiver or non-applicability of retroactive eligibility who returned their renewal form during the reconsideration period after a previous enrollment spell in the demonstration ended because the beneficiary did not comply with renewal processes on time	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	Y	Y	

[a] The reporting topics correspond to the prompts for the any demonstration (AD) reporting topic in Section 4 of the monitoring report template.

[b] If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column L.

[c] The state should use column L to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (Version 3.0)

State: Tennessee

Demonstration Name: TennCare III

Table: Eligibility and Coverage Demonstration Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: Income groups ***(Do not delete or edit this row)***	*EXAMPLE: Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE: Recommended*	*EXAMPLE: AD_1, AD_35 - AD_37*	*EXAMPLE: CMS-provided*	*EXAMPLE: Y*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	AD_1, AD_35 - AD_37 PR_1, PR_3, PR_15 - PR_17	CMS-provided	N				
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	AD_1, AD_35 - AD_37 PR_15 - PR_17	CMS-provided	N				
Exempt groups	Eligibility and income groups that are enrolled in the demonstration but are not required to participate in elements of the demonstration (such as paying premiums) for reasons other than income *EXAMPLE: Geographic exemptions, employer sponsored insurance exemptions, exemptions due to medical frailty*	Recommended	AD_1, AD_35 - AD_37	State-specific	N				
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE: Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Recommended	AD_1, AD_35 - AD_37 PR_1, PR_3, PR_15 - PR_17	State-specific	N				

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 3.0)

State: Tennessee

Demonstration Name: TennCare III

Table 1. Eligibility and Coverage Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates		
	AD	PR	RW
Dates of first demonstration year			
Start date	01/08/2021	01/08/2021	01/08/2021
End date	12/31/2021	12/31/2021	12/31/2021
Dates of first quarter of the baseline period for CMS-constructed metrics			
(EandC DY and Q) (Format DY#Q#; e.g. DY1Q1)	DY1Q1	DY1Q1	DY1Q1
Start date	01/01/2021	01/01/2021	01/01/2021
End date	03/31/2021	03/31/2021	03/31/2021
Broader section 1115 demonstration reporting period corresponding with the first EandC reporting quarter, if applicable. If there is no broader demonstration, fill in the first eligibility and coverage policy reporting period. (Format DY#Q#; e.g. DY1Q3)	DY1Q1	DY1Q1	DY1Q1
First monitoring report due date (per STCs) (MM/DD/YYYY)	05/31/2021	05/31/2021	05/31/2021
First monitoring report in which the state plans to report calendar year (CY) metrics with a 90 day lag			
(Format CY#; e.g. CY2019)	CY2021		
associated with monitoring report (Format DY#Q#;	DY2Q3		
DY and Q start date	07/01/2022		
DY and Q end date	09/30/2022		
Dates of last reporting quarter:			
Start date	10/01/2030	10/01/2030	10/01/2030
End date	12/31/2030	12/31/2030	12/31/2030

Table 2. Eligibility and Coverage Demonstration Reporting Schedule

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b]			Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)		
						AD	PR	RW			AD	PR	RW
01/01/2021	03/31/2021	05/31/2021	DY1Q1	None	Narrative information	DY1Q1	DY1Q1	DY1Q1					
				30 days	Month	DY1Q1	DY1Q1	DY1Q1					
				None	Quarter	DY1Q1							
				90 days	Quarter								
				90 days	Calendar year								
				None	Demonstration year								
04/01/2021	06/30/2021	08/29/2021	DY1Q2	None	Narrative information	DY1Q2	DY1Q2	DY1Q2					
				30 days	Month	DY1Q2	DY1Q2	DY1Q2					
				None	Quarter	DY1Q2							
				90 days	Quarter	DY1Q1		DY1Q1					
				90 days	Calendar year								
				None	Demonstration year								
07/01/2021	09/30/2021	11/29/2021	DY1Q3	None	Narrative information	DY1Q3	DY1Q3	DY1Q3					
				30 days	Month	DY1Q3	DY1Q3	DY1Q3					
				None	Quarter	DY1Q3							
				90 days	Quarter	DY1Q2		DY1Q2					
				90 days	Calendar year								
				None	Demonstration year								
10/01/2021	12/31/2021	03/31/2022	DY1Q4	None	Narrative information	DY1Q4	DY1Q4	DY1Q4					
				30 days	Month	DY1Q4	DY1Q4	DY1Q4					
				None	Quarter	DY1Q4							
				90 days	Quarter	DY1Q3		DY1Q3					
				90 days	Calendar year								
				None	Demonstration year								
01/01/2022	03/31/2022	05/30/2022	DY2Q1	None	Narrative information	DY2Q1	DY2Q1	DY2Q1					
				30 days	Month	DY2Q1	DY2Q1	DY2Q1					
				None	Quarter	DY2Q1							
				90 days	Quarter	DY1Q4		DY1Q4					
				90 days	Calendar year								
				None	Demonstration year								
04/01/2022	06/30/2022	08/29/2022	DY2Q2	None	Narrative information	DY2Q2	DY2Q2	DY2Q2					
				30 days	Month	DY2Q2	DY2Q2	DY2Q2					
				None	Quarter	DY2Q2							
				90 days	Quarter	DY2Q1		DY2Q1					
				90 days	Calendar year								
				None	Demonstration year								
07/01/2022	09/30/2022	11/29/2022	DY2Q3	None	Narrative information	DY2Q3	DY2Q3	DY2Q3					
				30 days	Month	DY2Q3	DY2Q3	DY2Q3					
				None	Quarter	DY2Q3							
				90 days	Quarter	DY2Q2		DY2Q2					
				90 days	Calendar year	CY2021							
				None	Demonstration year								
10/01/2022	12/31/2022	03/31/2023	DY2Q4	None	Narrative information	DY2Q4	DY2Q4	DY2Q4					
				30 days	Month	DY2Q4	DY2Q4	DY2Q4					
				None	Quarter	DY2Q4							
				90 days	Quarter	DY2Q3		DY2Q3					

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g., DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY 1Q3)[b]			Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)		
						AD	PR	RW			AD	PR	RW
				90 days	Calendar year								
				None	Demonstration year								
01/01/2023	03/31/2023	05/30/2023	DY3Q1	None	Narrative information	DY3Q1	DY3Q1	DY3Q1					
				30 days	Month	DY3Q1	DY3Q1	DY3Q1					
				None	Quarter	DY3Q1							
				90 days	Quarter	DY2Q4		DY2Q4					
				90 days	Calendar year								
				None	Demonstration year								
04/01/2023	06/30/2023	08/29/2023	DY3Q2	None	Narrative information	DY3Q2	DY3Q2	DY3Q2					
				30 days	Month	DY3Q2	DY3Q2	DY3Q2					
				None	Quarter	DY3Q2							
				90 days	Quarter	DY3Q1		DY3Q1					
				90 days	Calendar year								
				None	Demonstration year								
07/01/2023	09/30/2023	11/29/2023	DY3Q3	None	Narrative information	DY3Q3	DY3Q3	DY3Q3					
				30 days	Month	DY3Q3	DY3Q3	DY3Q3					
				None	Quarter	DY3Q3							
				90 days	Quarter	DY3Q2		DY3Q2					
				90 days	Calendar year	CY2022							
				None	Demonstration year								
10/01/2023	12/31/2023	03/30/2024	DY3Q4	None	Narrative information	DY3Q4	DY3Q4	DY3Q4					
				30 days	Month	DY3Q4	DY3Q4	DY3Q4					
				None	Quarter	DY3Q4							
				90 days	Quarter	DY3Q3		DY3Q3					
				90 days	Calendar year								
				None	Demonstration year								

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g., DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY 1Q3)[b]			Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)		
						AD	PR	RW			AD	PR	RW
01/01/2024	03/31/2024	05/30/2024	DY4Q1	None	Narrative information	DY4Q1	DY4Q1	DY4Q1					
				30 days	Month	DY4Q1	DY4Q1	DY4Q1					
				None	Quarter	DY4Q1							
				90 days	Quarter	DY3Q4		DY3Q4					
				90 days	Calendar year								
				None	Demonstration year								
04/01/2024	06/30/2024	08/29/2024	DY4Q2	None	Narrative information	DY4Q2	DY4Q2	DY4Q2					
				30 days	Month	DY4Q2	DY4Q2	DY4Q2					
				None	Quarter	DY4Q2							
				90 days	Quarter	DY4Q1		DY4Q1					
				90 days	Calendar year								
				None	Demonstration year								
07/01/2024	09/30/2024	11/29/2024	DY4Q3	None	Narrative information	DY4Q3	DY4Q3	DY4Q3					
				30 days	Month	DY4Q3	DY4Q3	DY4Q3					
				None	Quarter	DY4Q3							
				90 days	Quarter	DY4Q2		DY4Q2					
				90 days	Calendar year	CY2023							
				None	Demonstration year								
10/01/2024	12/31/2024	03/31/2025	DY4Q4	None	Narrative information	DY4Q4	DY4Q4	DY4Q4					
				30 days	Month	DY4Q4	DY4Q4	DY4Q4					
				None	Quarter	DY4Q4							
				90 days	Quarter	DY4Q3		DY4Q3					
				90 days	Calendar year								
				None	Demonstration year								

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY 1Q3)[b]			Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)		
						AD	PR	RW			AD	PR	RW
01/01/2025	03/31/2025	05/30/2025	DY5Q1	None	Narrative information	DY5Q1	DY5Q1	DY5Q1					
				30 days	Month	DY5Q1	DY5Q1	DY5Q1					
				None	Quarter	DY5Q1							
				90 days	Quarter	DY4Q4		DY4Q4					
				90 days	Calendar year								
				None	Demonstration year								

[a] **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at the time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "EandC reporting schedule tab" should align with the first day of a month. If a state's eligibility and coverage demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "EandC reporting schedule" tab. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

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 Development 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.

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.

The TennCare demonstration provides for a process by which the state and federal government share in savings generated under the demonstration. These shared savings are based in part on state performance on a set of specified quality performance measures. These measures are referred to as the Shared Savings Metric Set. The measures that comprise the Shared Savings Metric Set are identified in this protocol.

I. Shared Savings Metric Set

The state submits the following 10 measures to comprise the Shared Savings Metric Set for the TennCare demonstration. The Shared Savings Metric Set includes measures applicable to all demonstration populations (including measures from the Medicaid Adult, Child, and Maternity Core Sets), measures relevant to both medical/surgical and behavioral health conditions, and measures related to both preventive and acute care.

Table. Shared Savings Metric Set.

Metric	Measure Set
Controlling High Blood Pressure (CBP)	Adult Core Set
Follow-Up After Hospitalization for Mental Illness Ages 18-64, 30-day (FUH)	
Use of Pharmacotherapy for OUD (OUD)	
Follow-Up After Hospitalization for Mental Illness Ages 6-17, 30-day (FUH)	Child Core Set
Childhood Immunization Status, Combo 10 (CIS)	
Child and Adolescent Well-Care Visits (WCV)	
Timeliness of Prenatal Care (PPC)	Maternity
Postpartum Care (PPC)	
Well-Child Visits in the First 30 Months of Life, First 15 Months (W30)	
HCBS Rebalancing	LTSS

II. Deviations from National Measure Steward Technical Specifications

The state is proposing one deviation from the national measure steward technical specifications. The CMS Core Measure specifications for Controlling High Blood Pressure (CBP) includes two breakouts for age – 18-64 and 65-85. Tennessee has historically reported this measure as one cumulative value (ages 18-85), as that is how the measure is defined by NCQA/HEDIS, the measure sponsor. All other measures do not deviate from the CMS Core Measure Specifications.

III. Calculation of Shared Savings

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Shared savings will be calculated according to the special terms and conditions (STCs) of the TennCare demonstration, and based on (1) the extent (if any) to which demonstration expenditures in a given year are less than the aggregate budget neutrality cap for that year, and (2) state performance on the measures in the Shared Savings Metric Set. The calculation of shared savings is illustrated in the figure below.

Figure. Mathematical Representation of Shared Savings

$$\text{State Shared Savings Amount} = \left(\text{DY Aggregate Budget Neutrality Cap} - \text{DY Aggregate Demonstration Expenditures} \right) X \text{Quality Performance Adjustment}$$

The Quality Performance Adjustment is calculated as follows:

Performance on Shared Savings Metric Set	Quality Performance Adjustment Equal to
Performance on four or more measures exhibits significant decline from baseline for two consecutive years	0
Performance on three measures exhibits significant decline from baseline for two consecutive years	0.20
Performance on two measures exhibits significant decline from baseline for two consecutive years	0.25
Performance on one measure exhibits significant decline from baseline for two consecutive years	0.35
Performance on all 10 measures is maintained—no significant change from baseline OR significant decline for only one year on any given measure.[34]	0.45
Performance on all 10 measures is maintained or exhibits significant improvement from baseline.[35]	0.45 + 0.01 multiplied by the number of measures (up to 10) with significant improvement

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[34] Consistent with the STCs of the TennCare demonstration, if performance on any measure exhibits significant decline for one year, the state will submit a performance improvement plan to CMS. When calculating the quality performance adjustment for the first year of metric reporting, declines in metric performance will not impact the claiming of shared savings, which will have a minimum adjustment of 0.45, and will only be subject to adjustments based on significant improvements in metric performance.

[35] In addition, in any year in which the state demonstrates sufficient improvement on a shared savings measure to be in the 75th percentile or higher, the state will continue to access shared savings equivalent to what the state would otherwise have achieved through a significant improvement on that measure.

Significant Changes from Baseline

Consistent with the STCs of the TennCare demonstration, state performance on Shared Savings Metric Set measures in Calendar Year 2019 is the baseline for purposes of measuring change in state performance. Determination of whether an observed change (positive or negative) in performance is significant will be based on a minimum effect size change relative to the baseline performance. This minimum effect size change is defined as follows:

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

IV. Metric Replacement

Consistent with the STCs of the TennCare demonstration, once the state reaches the 90th percentile on a metric in Shared Savings Metric Set, the metric will be retired for purposes of achieving shared savings, and the state and CMS will identify a replacement quality metric.

Identification of the 90th percentile is done in two parts:

1) For the HEDIS measures, the state purchases annual Quality Compass data from NCQA, which includes 90th percentile data;
2) The state uses the information provided by CMS in the measure specific chart packs (that report each states rate) to calculate the 90th percentile for the measures.

Whenever possible, the state will use CMS data to calculate the 90th percentile. When this data is not available, the state will use NCQA Quality Compass data to identify the 90th percentile.

If the state determines that a metric meets the 90th percentile for a performance year, the state will notify CMS and propose a replacement metric. When a replacement metric is finalized by the state and CMS and that measure's baseline is confirmed, the new metric will be implemented during the following measurement year.

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Appendix

Measure Definitions

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Shared Savings Metric Set – Measure Definitions

The following measure definitions are taken from NCQA HEDIS MY2020[36] specifications. Any difference between the NCQA HEDIS specifications and CMS Core Measure specifications are noted.

Controlling High Blood Pressure (CBP) (HEDIS MY2020): Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequality controlled (<140/90 mm Hg) during the measurement year.

Difference between NCQA and CMS Specifications: NCQA specifications do not stratify by age groups while the CMS specifications stratify this measure into 18-64 and 65+ age groups. The state submits this measure in accordance with NCQA specifications for the entire age group.

Follow-Up After Hospitalization for Mental Illness (FUH) (HEDIS MY2020): Percentage of discharges for members ages 6+ who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis who had a follow up visit with a mental health practitioner.

- Members who received follow-up care within 30 days of discharge

Note that for purposes of the Shared Savings Metric Set, the state will track rates for children (ages 6 to 17) and adults (ages 18 to 64) separately.

Childhood Immunization Status (CIS) (HEDIS MY2020):

- Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophiles influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PVC); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measures calculated a rate for each vaccine and nine separate combination rates.

Note that for purposes of the Shared Savings Metric Set, the state will use the Combination 10 rate. Combination 10 includes DTaP, IPV, MMR, HiB, HepB, VZV, PVC, Hep A, RV, and Flu vaccinations.

Child and Adolescent Well-Care Visits (WCV) (HEDIS MY2020): Percentage of members 3-21 years of age who had at least one comprehensive well-care visits with a PCP or OB/GYN during the measurement year

Note that this measure is a combination of the previous, W34 (Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life) and AWC (Adolescent Well-Care Visits) measures. Due to these changes in specifications, Tennessee will calculate this measure for Calendar Year 2019 using the updated specifications to establish the baseline.

Prenatal and Postpartum Care (PPC) (HEDIS MY2020): Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

[36] NCQA HEDIS MY2020 refers to the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set, Measurement Year 2020.

RESCINDED

- *Timeliness of Prenatal Care:* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization
- *Postpartum Care:* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Well-Child Visits in the First 30 Months of Life (W30) (HEDIS MY2020): Percentage of members who had the following number of well-child visits with a PCP in the last 15 months:

- *Well-Child Visits in the First 15 Months:* Children who turned 15 months old during the measurement year: 6 or more visits.

Note that NCQA has made minor changes to the specifications to this measure since the approval of the TennCare III demonstration. Due to these changes in specifications, Tennessee will calculate this measure for Calendar Year 2019 using the updated specifications to establish the baseline.

The following definition is taken from the CMS Core Measure Specifications from MY2019.

Use of Pharmacotherapy for Opioid Use Disorder (OUD) (Core Measure MY2019):

- Percentage of Medicaid members ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:
    - Total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction
    - Four Separate rates representing the following types of FDA-approved drug products:
        - Buprenorphine
        - Oral Naltrexone
        - Long-acting, Injectable Naltrexone
        - Methadone

Note that for purposes of the Shared Savings Metric Set, the state will use the total (overall) rate.

Also note that Use of Pharmacotherapy for Opioid Use Disorder (OUD) was added by CMS to the Adult Core Set in 2020. In order to establish a baseline for this measure consistent with the other measures in the Shared Savings Metric Set, Tennessee will calculate the measure for Calendar Year 2019 using the CMS specifications for 2020.

HCBS Rebalancing:

- Percentage of individuals with intellectual or developmental disabilities receiving Medicaid-reimbursed LTSS in the community. The numerator is the number of individuals with intellectual or developmental disabilities receiving Medicaid-reimbursed LTSS in the community (i.e., HCBS). The denominator is the number of individuals with intellectual or developmental disabilities receiving any Medicaid-reimbursed LTSS services.

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Attachment P

Shared Savings Quality Measures Protocol (Rescinded)

Shared Savings Metric Set – Measure Definitions

The following measure definitions are taken from NCQA HEDIS MY2020[36] specifications. Any difference between the NCQA HEDIS specifications and CMS Core Measure specifications are noted.

Controlling High Blood Pressure (CBP) (HEDIS MY2020): Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequality controlled (<140/90 mm Hg) during the measurement year.

Difference between NCQA and CMS Specifications: NCQA specifications do not stratify by age groups while the CMS specifications stratify this measure into 18-64 and 65+ age groups. The state submits this measure in accordance with NCQA specifications for the entire age group.

Follow-Up After Hospitalization for Mental Illness (FUH) (HEDIS MY2020): Percentage of discharges for members ages 6+ who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis who had a follow up visit with a mental health practitioner.

- Members who received follow-up care within 30 days of discharge

Note that for purposes of the Shared Savings Metric Set, the state will track rates for children (ages 6 to 17) and adults (ages 18 to 64) separately.

Childhood Immunization Status (CIS) (HEDIS MY2020):

- Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophiles influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PVC); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measures calculated a rate for each vaccine and nine separate combination rates.

Note that for purposes of the Shared Savings Metric Set, the state will use the Combination 10 rate. Combination 10 includes DTaP, IPV, MMR, HiB, HepB, VZV, PVC, Hep A, RV, and Flu vaccinations.

Child and Adolescent Well-Care Visits (WCV) (HEDIS MY2020): Percentage of members 3-21 years of age who had at least one comprehensive well-care visits with a PCP or OB/GYN during the measurement year

Note that this measure is a combination of the previous, W34 (Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life) and AWC (Adolescent Well-Care Visits) measures. Due to these changes in specifications, Tennessee will calculate this measure for Calendar Year 2019 using the updated specifications to establish the baseline.

[36] NCQA HEDIS MY2020 refers to the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set, Measurement Year 2020.

RESCINDED

Attachment P

Shared Savings Quality Measures Protocol (Rescinded)

Prenatal and Postpartum Care (PPC) (HEDIS MY2020): Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- *Timeliness of Prenatal Care:* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization
- *Postpartum Care:* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Well-Child Visits in the First 30 Months of Life (W30) (HEDIS MY2020): Percentage of members who had the following number of well-child visits with a PCP in the last 15 months:

- *Well-Child Visits in the First 15 Months:* Children who turned 15 months old during the measurement year: 6 or more visits.

Note that NCQA has made minor changes to the specifications to this measure since the approval of the TennCare III demonstration. Due to these changes in specifications, Tennessee will calculate this measure for Calendar Year 2019 using the updated specifications to establish the baseline.

The following definition is taken from the CMS Core Measure Specifications from MY2019.

Use of Pharmacotherapy for Opioid Use Disorder (OUD) (Core Measure MY2019):

- Percentage of Medicaid members ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:
    - Total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction
    - Four Separate rates representing the following types of FDA-approved drug products:
        - Buprenorphine
        - Oral Naltrexone
        - Long-acting, Injectable Naltrexone
        - Methadone

Note that for purposes of the Shared Savings Metric Set, the state will use the total (overall) rate.

Also note that Use of Pharmacotherapy for Opioid Use Disorder (OUD) was added by CMS to the Adult Core Set in 2020. In order to establish a baseline for this measure consistent with the other measures in the Shared Savings Metric Set, Tennessee will calculate the measure for Calendar Year 2019 using the CMS specifications for 2020.

HCBS Rebalancing:

- Percentage of individuals with intellectual or developmental disabilities receiving Medicaid-reimbursed LTSS in the community. The numerator is the number of individuals with intellectual or developmental disabilities receiving Medicaid-reimbursed LTSS in the community (i.e., HCBS). The denominator is the number of individuals with intellectual or developmental disabilities receiving any Medicaid-reimbursed LTSS services.

RESCINDED

Attachment Q

Claiming Protocol for Designated State Investment Programs

1. As described in Special Terms and Conditions (STC) 32 of this 1115 demonstration, Designated State Investment Program (DSIP) expenditures may be claimed for the duration of the 1115 demonstration, commonly referred to as TennCare III. This duration is January 8, 2021, through December 31, 2030.

2. Nothing in this Attachment is intended to override any of the requirements or processes outlined in the STCs for the identification of DSIP expenditures, the process for claiming Shared Savings against the DSIP expenditures, or the amount of Shared Savings the State may claim.

3. The State's DSIPs are detailed in *Attachment O*. They include:

Agency	Program
Department of Health	Community and Faith-Based Clinics
Department of Mental Health and Substance Abuse Services	Behavioral Health Safety Net
Department of Intellectual and Developmental Disabilities	SafetyNet – ID/DD Services
Department of Education	K-12 Nurses
Department of Education	K-12 Psychologists
Department of Education	K-12 Social Workers
Department of Education	At-Risk Student Services
Division of Tenncare	CoverRx Prescription Medication Support

4. In establishing eligible DSIP expenditures against which Shared Savings may be claimed, the State will provide CMS with a summary Excel worksheet by agency, program and expenditure amounts. The format of this document, including appropriate levels of additional detail, shall be agreed to by the State and by CMS to ensure the State is providing CMS-approved data that can be reviewed and tested as needed.

5. The State uses a statewide accounting software system, Edison, as the accounting system of record for the State of Tennessee. All payments made by the State are recorded in Edison. Edison is managed by the Division of Accounts, which is part of the Tennessee Department of Finance and Administration. Departments of Tennessee State Government use Edison as their accounting system of record; this is true for TennCare as well as for the Departments that have expense identified as DSIP expenses. Edison provides all financial data for use in the compilation of the State's Comprehensive Annual Financial Report (CAFR) and for all audits including the annual Single Audit conducted by the State's Office of the Comptroller. Eligible state dollar DSIP expenses will be tracked and identified in Edison.

6. Eligible DSIP expenses from local expenditures in the K-12 Nurse, K-12 Psychologist, K-12 Social Worker, and At-Risk Student Services programs will be tracked in consultation with the Tennessee Department of Education and Local Education Authorities (LEAs). The eligible DSIP expenses from local expenditures in these programs will be attested to by LEAs.

RESCINDED

7. There are no funds approved for FFP in TennCare III included in eligible DSIP expenses.

8. As outlined in STC 32, allowable expenses include:
    a. Medicaid services for non-Medicaid eligible people
    b. Non-Medicaid services for Medicaid eligible people
    c. Medicaid provider stabilization payments for current Medicaid services for people at-risk for Medicaid if services are not received

9. As outlined in STC 32, non-allowable expenses include:
    a. Capital investments
    b. Expenditures that are not health-related
    c. Any expenditure that is otherwise prohibited by statute or regulation

10. To ensure all expenses reported to CMS as eligible DSIP expenses are accurate and are in fact eligible DSIP expenses, the State will:
    a. Work with the Division of Accounts and the Division of Budget in the Department of Finance and Administration to track eligible DSIP expenses, adjust DSIP expenses as needed to remove any ineligible costs, and to identify final amounts of eligible EDIP expense for each DY.
    b. Work with an independent contractor to track eligible DSIP expenses, adjusted DSIP expenses as needed to remove any ineligible costs, and to identify final amounts of eligible DSIP expense for each DY. This will serve as a backup process to the work described in 7.a.
    c. In the event of a material discrepancy between the eligible DSIP expenses identified in 7.a. and 7.b., the eligible DSIP expenses identified in 7.a. shall be used.
    d. The State will ensure that all data used in the completion of work in 7.a. and 7.b. shall be available to CMS for review.

11. The State shall identify eligible DSIP expenses to CMS in a two-step process:
    a. In the first quarter of each DY, the State will prepare an estimate of the eligible DSIP expenses for the DY year prior. For example, in DY2 Q1, the State will prepare an estimate of the DY1 eligible DSIP expenses. This estimate will be provided to CMS and will serve as the level of eligible DSIP expense to be used in establishing the amount of Shared Savings the State may receive.
    b. In the third quarter of each DY, the State will prepare finalized eligible DSIP expenses for the DY year prior. For example, in DY2 Q3, the State will provide CMS a finalized amount of eligible DSIP expenses for DY1. This finalized amount will be provided to CMS and will serve as the final complete total for eligible DSIP expenses for that DY. Any required adjustments to the amount of Shared Savings the State may receive will follow.
    c. Eligible DSIP expenses shall be identified in the following order based on the amount of shared savings available for the DY:
        i. Funding is first applied to eligible expenses within the CoverRx medication assistance program.
        ii. If additional funding remains, that funding would be applied to the state's ID/DD Safety Net program.
        iii. If additional funding remains, that funding would then be applied to the Behavioral Health Safety Net program.

iv. If additional funding remains, that funding would be applied to the Department of Health's community/faith-based clinics program.
v. If additional funding remains, that funding would be applied to Education/K-12 Nurses.
vi. If additional funding remains, that funding would be applied to Education/K-12 Psychologists.
vii. If additional funding remains, that funding would be applied to Education/K-12 Social Workers.
viii. If additional funding remains, that funding would be applied to Education/K-12 At Risk Student Services.

12. Shared savings will be calculated according to the special terms and conditions (STCs) of the TennCare demonstration. As noted in the STCs this is based on (1) the extent (if any) to which demonstration expenditures in a given year are less than the aggregate budget neutrality cap for that year, and (2) state performance on the measures in the Shared Savings Metric Set. The calculation of shared savings is illustrated below.

$$\text{State Shared Savings Amount} = \left(\text{DY Aggregate Budget Neutrality Cap} - \text{DY Aggregate Demonstration Expenditures} \right) \times \text{Quality Performance Adjustment}$$

13. The Quality Performance Adjustment is calculated as follows:

Performance on Shared Savings Metric Set	Quality Performance Adjustment Equal to
Performance on four or more measures exhibits significant decline from baseline for two consecutive years	0
Performance on three measures exhibits significant decline from baseline for two consecutive years	0.20
Performance on two measures exhibits significant decline from baseline for two consecutive years	0.25
Performance on one measure exhibits significant decline from baseline for two consecutive years	0.35
Performance on all 10 measures is maintained—no significant change from baseline OR significant decline for only one year on any given measure[1]	0.45

[1] Consistent with the STCs of the TennCare demonstration, if performance on any measure exhibits significant decline for one year, the state will submit a performance improvement plan to CMS. When calculating the quality performance adjustment for the first year of metric reporting, declines in metric performance will not impact the claiming of shared savings, which will have a minimum adjustment of 0.45, and will only be subject to adjustments based on significant improvements in metric performance.

RESCINDED

Performance on Shared Savings Metric Set	Quality Performance Adjustment Equal to
Performance on all 10 measures is maintained or exhibits significant improvement from baseline[2]	0.45 + 0.01 multiplied by the number of measures (up to 10) with significant improvement

14. Consistent with the STCs of the TennCare demonstration, state performance on Shared Savings Metric Set measures in Calendar Year 2019 is the baseline for purposes of measuring change in state performance. Determination of whether an observed change (positive or negative) in performance is significant will be based on a minimum effect size change relative to the baseline performance. This minimum effect size change is defined as follows:

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

15. The State will use the most recent available completed Shared Savings Metric Set for the calculation of the Shared Savings amount the State is eligible to receive. For example, to calculate the Shared Savings amount the State is eligible to receive for DY 2, the State will use the most recent available completed Shared Savings Metric Set in Q1 of DY3.

RESCINDED

[2] In addition, in any year in which the state demonstrates sufficient improvement on a shared savings measure to be in the 75th percentile or higher, the state will continue to access shared savings equivalent to what the state would otherwise have achieved through a significant improvement on that measure.

Division of TennCare

January 28, 2022

April Wiley
State Demonstrations Group
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-26-06
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Notice of Changes to Coverage and Benefits under the TennCare Demonstration

Dear Ms. Wiley,

Pursuant to the terms and conditions of the TennCare Demonstration, Tennessee is providing official notice to CMS of our intent to make changes to coverage and benefits available under the Demonstration. These changes add allowable benefits and coverage, as permitted by the Demonstration's STCs.

Specifically, Tennessee plans to implement two changes to coverage and benefits under the Demonstration:

1. Providing 12 months of postpartum coverage to individuals enrolled in TennCare; and
2. Implementing a dental benefit for pregnant and postpartum individuals enrolled in TennCare.

Both of these changes are scheduled for implementation beginning April 1, 2022.

We are pleased to be able to make these enhancements to coverage and benefits available under TennCare. We believe that these changes will lead to improvements in maternal and child health outcomes in Tennessee and will advance CMS's and Tennessee's shared goals of improving coverage, quality of care, and health outcomes for Medicaid beneficiaries.

A fuller description of these changes is attached to this letter. In addition, we have attached documentation of the state's compliance with the public notice requirements outlined in the Demonstration's STCs.

If you have any questions about this notice or if you need additional information, please contact Aaron Butler at 615.507.6448, or aaron.c.butler@tn.gov.

Sincerely,

[redacted]

Stephen Smith
Director, Division of TennCare

Attachments

Attachment A

Description of Changes to Coverage and Benefits

Division of TennCare • 310 Great Circle Road • Nashville, TN 37243
Tel: 800-342-3145 • tn.gov/tenncare

Description of Changes to Coverage and Benefits

The following provisions related to coverage and benefits under the TennCare Demonstration will become effective on April 1, 2022.

1. **Postpartum coverage for individuals enrolled in TennCare will last for 12 months.** Coverage for individuals enrolled in TennCare who are pregnant will last for 12 months (through the last day of the month in which the 12-month postpartum period, which began on the last day of pregnancy, ends). Individuals impacted by this change will continue to be enrolled in managed care and will continue to receive the full TennCare benefits package during their 12 months of postpartum coverage.[1]

2. **Dental benefits will be covered for pregnant and postpartum enrollees age 21 and older.** Dental services for pregnant and postpartum enrollees will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare enrollees.

   Dental benefits covered for pregnant and postpartum enrollees age 21 and older will consist of diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics (1 root canal per member per eligibility period); scaling and root planing; full mouth debridement; crowns (2 per member per eligibility period); complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; and palliative treatment.[2]

[1] See Section 1902(e)(16) of the Social Security Act.
[2] See 42 CFR §§ 440.100 and 440.250.

Attachment B

Description of Public Notice and Input

Description of Public Notice and Input

Effective April 1, 2022, postpartum coverage available under the TennCare Demonstration will last for 12 months, and dental services will be covered for pregnant and postpartum TennCare enrollees. TennCare has taken a variety of steps to ensure that members of the public have been notified of these planned changes and have had an opportunity to provide comments and input. These measures were informed by—and comply with—the STCs of the TennCare Demonstration and 42 CFR § 431.408.

Public Notice

The state held a formal notice and comment period on these proposed changes to coverage and benefits from December 17, 2021, through January 20, 2022. During this time, a comprehensive description of the planned changes was made available for public review and comment on a designated page on the TennCare website. An abbreviated public notice—which included a summary description of the planned changes; the locations, dates, and times of two public hearings; and a link to the full public notice on the state's website—was published in the newspapers of widest circulation in Tennessee communities with 50,000 or more residents.

The state held two public hearings to seek public comment on these planned changes to coverage and benefits. These hearings took place on January 5, 2022, at 10:00 a.m. CT and January 13, 2022, at 2:30 p.m. CT. Both hearings were conducted virtually.[3] Members of the public also had the option to submit comments throughout the notice period by mail and/or email.

In addition, both of these planned changes were presented as funding requests by TennCare during the 2021 session of the Tennessee General Assembly and were approved by the General Assembly as part of the state budget through a public legislative process.

On September 24, 2021, TennCare filed a notice of proposed rulemaking in accordance with Tennessee's Uniform Administrative Procedures Act to reflect these changes in TennCare's administrative rules. TennCare held a public rulemaking hearing on November 15, 2021, to receive public comments on these changes.

In addition, TennCare disseminated information about these proposed changes, including a link to the relevant information on TennCare's website, via its social media accounts (i.e., Facebook, Twitter).

Public Comments

TennCare received four sets of comments on these proposed changes from individuals or organizations, either in writing or at one of the public hearings. These comments are summarized below. In addition, comments received in writing are attached in their entirety as Attachment D.

[3] An in-person hearing scheduled for January 6, 2022, was canceled and rescheduled as a virtual hearing due to severe winter weather in Nashville on January 6.

All four sets of comments were supportive of extending postpartum coverage under the TennCare Demonstration to 12 months. In addition, three of the four commenters were supportive of implementing a dental benefit for pregnant and postpartum TennCare enrollees. Commenters generally believed that these coverage enhancements will support improved maternal health outcomes for individuals enrolled in TennCare.

The state thanks these commenters for their support.

One set of commenters expressed concern that TennCare enrollees may be subject to nominal cost sharing for prescription drugs during a portion of their postpartum coverage. These commenters suggested that cost sharing may serve as a barrier to accessing care.

The state thanks these commenters for their comments. As indicated in the state's public notice, TennCare will follow federal rules regarding cost sharing during the postpartum period. Currently, federal regulations at 42 CFR § 447.56(a)(1)(vii) specify that pregnant women are exempt from cost sharing during their pregnancy and through the end of the month in which the 60-day postpartum period ends. Should CMS amend this regulation or otherwise advise the state that postpartum enrollees should be exempt from cost sharing for the entirety of their 12-month postpartum coverage, TennCare will modify its cost sharing policies accordingly. Otherwise, the state interprets the intent of the regulation to be that enrollees are to be subject to regular copays after 60 days postpartum.

As a practical matter, the only cost sharing applicable to Medicaid enrollees in Tennessee is nominal copays for prescription drugs ($3 for brand name drugs and $1.50 for generic drugs). These copays are well below the maximum amounts permitted in regulation and are unenforceable. The state does not believe these copays are a significant barrier to access.

One set of commenters recommended that the state pursue these program modifications through the State Plan Amendment process rather than through the process outlined in the TennCare Demonstration. These commenters speculated that litigation may result in changes to the TennCare Demonstration.

The state respectfully disagrees with these commenters. The TennCare Demonstration expressly allows the state to make allowable changes to coverage and benefits, while still providing a robust framework for oversight and transparency regarding modifications to the program. Seeking additional federal approvals through the regular State Plan Amendment process would not result in any benefit for CMS, the state, or the state's Medicaid beneficiaries.

Attachment C

Documentation of Public Notice

Notice of Change to the TennCare III Program
Maternal Health Enhancements

December 17, 2021

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of planned changes to the TennCare program. These changes entail enhancements to coverage for pregnant and postpartum women enrolled in TennCare. TennCare is publishing this notice pursuant to 42 § CFR 431.408 and the terms and conditions of the TennCare Demonstration in order to solicit public input on these planned changes.

Description of Planned Program Changes

TennCare is providing official notification of its intent to make two changes to the TennCare program. Both of these changes will become effective on April 1, 2022.

1. **Extension of postpartum coverage**. TennCare's coverage of pregnant women currently includes approximately 60 days of postpartum coverage following the end of the pregnancy.[1] Effective April 1, 2022, TennCare will provide 12 months of postpartum coverage following the end of pregnancy. Members impacted by this change will continue to be enrolled in managed care and will continue to receive the full TennCare benefits package during their 12 months of postpartum coverage.[2]

2. **Dental coverage for pregnant and postpartum women.** Pregnant and postpartum women age 21 and older do not currently receive a dental benefit from TennCare. Effective April 1, 2022, TennCare will provide a dental benefits package for these members for the duration of their pregnancy and postpartum coverage.

   Dental services for pregnant and postpartum women will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members. Dental benefits covered for pregnant and postpartum

[1] TennCare currently provides coverage through the last day of the month in which the 60-day postpartum period ends. See 42 § CFR 435.170.

[2] These members may be subject to nominal copays for prescription drugs during their period of extended postpartum coverage ($3 for brand name drugs, $1.50 for generic drugs). Federal regulation currently exempts members from cost sharing during pregnancy and for 60 days postpartum. TennCare is awaiting federal guidance on whether this cost sharing exemption will be extended for the entire 12-month postpartum period or whether postpartum members will be subject to regular adult copays after 60 days.

members age 21 and older will include diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics (1 root canal per member per eligibility period); scaling and root planing; full mouth debridement; crowns (2 per member per eligibility period); complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; and palliative treatment.

Expected Impact on Enrollment and Expenditures

These changes will not result in the enrollment of additional persons in the TennCare program. The extension of TennCare postpartum coverage is expected to result in an increase in annual aggregate expenditures of approximately $20 million under the TennCare program. The addition of a dental benefit for pregnant and postpartum members is expected to result in an increase in annual aggregate expenditures of approximately $6 million under the TennCare program.

Evaluation Impact

TennCare does not anticipate modifying its evaluation design based on these planned changes. These changes are expected to contribute to key goals of the TennCare Demonstration already reflected in the demonstration's evaluation design (currently under CMS review). These include enhancing coverage and benefits available under the TennCare Demonstration and improving prenatal/postpartum care available under the TennCare Demonstration.

Waiver and Expenditure Authorities Requested

TennCare is not requesting any new waiver or expenditure authorities under Section 1115 of the Social Security Act to implement these changes.

- Section 1902(e)(16) of the Social Security Act allows state Medicaid programs to provide coverage to pregnant women for 12 months postpartum (through the last day of the month in which the 12-month postpartum period, which began on the last of pregnancy, ends).
- Federal regulations at 42 CFR §§ 440.100 and 440.250 allow state Medicaid programs to provide dental services to eligible beneficiaries, and to provide services to pregnant women in a greater amount, duration, and scope than that provided to non-pregnant beneficiaries.

Under the terms of the TennCare III Demonstration, TennCare may make changes that add allowable benefits and coverage to the program without seeking additional approval of a demonstration amendment from the Centers for Medicare & Medicaid Services (CMS).

Public Notice Process

TennCare has taken a variety of steps to ensure that members of the public are notified of these planned changes to the TennCare program. These measures include the development and maintenance of this webpage, as well as notices published in newspapers of general circulation in Tennessee communities with 50,000 or more residents.

Both of these planned changes were presented by TennCare as budget requests during the 2021 legislative session and were approved by the Tennessee General Assembly as part of the state budget through a public legislative process.

On September 24, 2021, TennCare filed a notice of rulemaking hearing in accordance with Tennessee's Uniform Administrative Procedures Act to reflect these changes in TennCare's administrative rules. TennCare held a public rulemaking hearing to receive public comments on these changes on November 15, 2021.

In addition, TennCare has disseminated information about these proposed changes via its social media accounts (e.g., Facebook, Twitter).

Public Input Process

TennCare is seeking feedback on these planned changes. Members of the public are invited to offer comments regarding these changes from December 17, 2021, through January 20, 2022.

Members of the public who wish to comment on these planned changes may do so through either of the following options:

- Comments may be sent by email to public.notice.tenncare@tn.gov.
- Comments may be mailed to

Aaron Butler, Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

Virtual Hearing
Location:
https://tngov.webex.com/meet/JReeve
Date: January 5, 2022
Time: 10:00 a.m. CT

In-Person Hearing
Location: The PEARL Room on the ground floor of the Tennessee Department of Labor and Workforce Development, 220 French Landing Drive, Nashville, TN.
Date: January 6, 2022
Time: 2:30 p.m. CT

TennCare always appreciates input. In order to be considered prior to implementation of these changes, feedback must be received no later than January 20, 2022. Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.

TennCare Demonstration

A copy of the TennCare Demonstration is available at https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.

TennCare Page on CMS Web Site

As the federal agency with oversight authority over all Medicaid programs, CMS offers its own online resources regarding the TennCare Demonstration. Interested parties may view these materials at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

Notice of Change to the TennCare III Program
Maternal Health Enhancements

December 17, 2021
Updated January 6, 2022

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of planned changes to the TennCare program. These changes entail enhancements to coverage for pregnant and postpartum women enrolled in TennCare. TennCare is publishing this notice pursuant to 42 § CFR 431.408 and the terms and conditions of the TennCare Demonstration in order to solicit public input on these planned changes.

Description of Planned Program Changes

TennCare is providing official notification of its intent to make two changes to the TennCare program. Both of these changes will become effective on April 1, 2022.

1. **Extension of postpartum coverage**. TennCare's coverage of pregnant women currently includes approximately 60 days of postpartum coverage following the end of the pregnancy.[1] Effective April 1, 2022, TennCare will provide 12 months of postpartum coverage following the end of pregnancy. Members impacted by this change will continue to be enrolled in managed care and will continue to receive the full TennCare benefits package during their 12 months of postpartum coverage.[2]

2. **Dental coverage for pregnant and postpartum women.** Pregnant and postpartum women age 21 and older do not currently receive a dental benefit from TennCare. Effective April 1, 2022, TennCare will provide a dental benefits package for these members for the duration of their pregnancy and postpartum coverage.

   Dental services for pregnant and postpartum women will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services

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[2] These members may be subject to nominal copays for prescription drugs during their period of extended postpartum coverage ($3 for brand name drugs, $1.50 for generic drugs). Federal regulation currently exempts members from cost sharing during pregnancy and for 60 days postpartum. TennCare is awaiting federal guidance on whether this cost sharing exemption will be extended for the entire 12-month postpartum period or whether postpartum members will be subject to regular adult copays after 60 days.

to TennCare members. Dental benefits covered for pregnant and postpartum members age 21 and older will include diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics (1 root canal per member per eligibility period); scaling and root planing; full mouth debridement; crowns (2 per member per eligibility period); complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; and palliative treatment.

Expected Impact on Enrollment and Expenditures

These changes will not result in the enrollment of additional persons in the TennCare program. The extension of TennCare postpartum coverage is expected to result in an increase in annual aggregate expenditures of approximately $20 million under the TennCare program. The addition of a dental benefit for pregnant and postpartum members is expected to result in an increase in annual aggregate expenditures of approximately $6 million under the TennCare program.

Evaluation Impact

TennCare does not anticipate modifying its evaluation design based on these planned changes. These changes are expected to contribute to key goals of the TennCare Demonstration already reflected in the demonstration's evaluation design (currently under CMS review). These include enhancing coverage and benefits available under the TennCare Demonstration and improving prenatal/postpartum care available under the TennCare Demonstration.

Waiver and Expenditure Authorities Requested

TennCare is not requesting any new waiver or expenditure authorities under Section 1115 of the Social Security Act to implement these changes.

- Section 1902(e)(16) of the Social Security Act allows state Medicaid programs to provide coverage to pregnant women for 12 months postpartum (through the last day of the month in which the 12-month postpartum period, which began on the last of pregnancy, ends).
- Federal regulations at 42 CFR §§ 440.100 and 440.250 allow state Medicaid programs to provide dental services to eligible beneficiaries, and to provide services to pregnant women in a greater amount, duration, and scope than that provided to non-pregnant beneficiaries.

Under the terms of the TennCare III Demonstration, TennCare may make changes that add allowable benefits and coverage to the program without seeking additional approval of a demonstration amendment from the Centers for Medicare & Medicaid Services (CMS).

Public Notice Process

TennCare has taken a variety of steps to ensure that members of the public are notified of these planned changes to the TennCare program. These measures include the development and maintenance of this webpage, as well as notices published in newspapers of general circulation in Tennessee communities with 50,000 or more residents.

Both of these planned changes were presented by TennCare as budget requests during the 2021 legislative session and were approved by the Tennessee General Assembly as part of the state budget through a public legislative process.

On September 24, 2021, TennCare filed a notice of rulemaking hearing in accordance with Tennessee's Uniform Administrative Procedures Act to reflect these changes in TennCare's administrative rules. TennCare held a public rulemaking hearing to receive public comments on these changes on November 15, 2021.

In addition, TennCare has disseminated information about these proposed changes via its social media accounts (e.g., Facebook, Twitter).

Public Input Process

TennCare is seeking feedback on these planned changes. Members of the public are invited to offer comments regarding these changes from December 17, 2021, through January 20, 2022.

Members of the public who wish to comment on these planned changes may do so through either of the following options:

- Comments may be sent by email to public.notice.tenncare@tn.gov.
- Comments may be mailed to

  Aaron Butler, Director of Policy
  Division of TennCare
  310 Great Circle Road
  Nashville, TN 37243.

Individuals who prefer to make their comments verbally may participate in one of the following public hearings to comment on these planned changes:

Virtual Hearing
Location:
https://tngov.webex.com/meet/JReeve
Date: January 5, 2022
Time: 10:00 a.m. CT

Virtual Hearing
Location:
https://tngov.webex.com/meet/JReeve
Date: January 13, 2022
Time: 2:30 p.m. CT

The public hearing originally scheduled for January 6, 2022, was rescheduled for January 13, 2022, due to inclement weather. Details of the rescheduled hearing are listed above.

TennCare always appreciates input. In order to be considered prior to implementation of these changes, feedback must be received no later than January 20, 2022. Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.

TennCare Demonstration

A copy of the TennCare Demonstration is available at https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.

TennCare Page on CMS Web Site

As the federal agency with oversight authority over all Medicaid programs, CMS offers its own online resources regarding the TennCare Demonstration. Interested parties may view these materials at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

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8 hrs ·

Due to anticipated inclement weather, TennCare's public hearing on maternal health enhancements scheduled for January 6 will be rescheduled. Details about the new date and time will be posted on TennCare's website.

1

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TennCare
December 31, 2021 at 5:00 AM ·

Our offices are closed today (Dec. 31) and Monday (Jan. 3) for the New Year holiday! We hope you have a safe and joyful new year!



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TennCare is Tennessee's Medicaid program which serves 1.6 million Tennesseans.
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1 hr ·
TennCare's public hearing on maternal health enhancements has been rescheduled for January 13, 2022, at 2:30 p.m. CT. More details about this rescheduled event are at
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TennCare's public hearing on maternal health enhancements has been rescheduled for January 13, 2022, at 2:30 p.m. CT. More details about this rescheduled event are at tn.gov/content/dam/tn...

TennCare @TennCareRep · 8h
Due to anticipated inclement weather, TennCare's public hearing on maternal health enhancements scheduled for January 6 will be rescheduled. Details about the new date and time will be posted on TennCare's website.

1

TennCare Retweeted

TN Dept. of Human Resources @DOHRtn · 9h
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Before me personally appeared Jim Stevens, who being duly sworn that he is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

Chattanooga Times Free Press: 12/21/21; TimesFreePress.com: 12/21/21.

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $400.70. (Includes $10.00 Affidavit Ch g

[redacted]

Sworn to and subscribed before me this date: 12/27/2021

[redacted]

My Commission Expires 02/28/2023

Sammie K. Thompson-Kilgore
STATE OF TENNESSEE NOTARY PUBLIC HAMILTON COUNTY

Chattanooga
Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 37403

NOTICE OF CHANGE IN THE TENNCARE PROGRAM MATERNAL HEALTH ENHANCEMENTS

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes entail enhancements to TennCare's coverage of pregnant and postpartum women enrolled in TennCare. This notice is provided in order to solicit public input on these planned changes.

TennCare's coverage of pregnant women currently includes approximately 60 days of postpartum coverage following the end of the pregnancy. Effective April 1, 2022, TennCare will provide 12 months of postpartum coverage following the end of pregnancy. Members impacted by this change will continue to be enrolled in managed care and will continue to receive the full TennCare benefits package during their 12 months of postpartum coverage.

Pregnant and postpartum women age 21 and older do not currently receive a dental benefit from TennCare. Effective April 1, 2022, TennCare will provide a dental benefits package for these members for the duration of their pregnancy and postpartum coverage. Dental services for pregnant and postpartum women will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members.

These changes will not result in the enrollment of additional persons in the TennCare program. The extension of TennCare postpartum coverage is expected to result in an increase in annual aggregate expenditures of approximately $20 million under the TennCare program. The addition of a dental benefit for pregnant and postpartum members is expected to result in an increase in annual aggregate expenditures of approximately $6 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/ChangeTennCareIIIProgramMaternalHealthEnhancements.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than January 20, 2022.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

- A public hearing will be held electronically on January 5, 2022, at 10:00 a.m. CT. Member of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of January 5, 2022.
- A public hearing will be held in person on January 6, 2022, at 2:30 p.m. CT in the PEARL Room on the ground floor of the Tennessee Department of Labor and Workforce Development, 220 French Landing Drive in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

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TENNCARE BUREAU STAT
310 GREAT CIRCLE RD

NASHVILLE, TN 37243-1700

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Affidavit of Publication

STATE OF WISCONSIN
County of Brown

Personally appeared before me, said Legal clerk of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennesse, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached notice was published in the following issue(s) dated of The Commercial Appeal:

12/23/2021

TENNCARE BUREAU STAT 307573

[redacted]

Subscribe and sworn to before me this 23th day of December, 2021

[redacted]

Notary Public

1-7-25

My commission expires

KATHLEEN ALLEN
Notary Public
State of Wisconsin

# of Affidavits 1
Ad Number: 0005056854

Notice of Change in the TennCare Program Maternal Health Enhancements

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes entail enhancements to TennCare's coverage of pregnant and postpartum women enrolled in TennCare. This notice is provided in order to solicit public input on these planned changes.

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Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

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The following vehicles will be sold at vehicle auction for Mechanics liens/storage fees on Friday January 7, 2022 at 11:30am: 02 Mercedes C320 Black WDBRF64J62E064083; 07 Mercedes S550 dark blue paint is primered down WDDNG71X37A139107 Christ-Like Automotive Repair, LLC 1885c Bartlett Rd. Memphis, Tn 38134 (901)220-3974.

Legal Notices

Notice of Change in the TennCare Program Maternal Health Enhancements

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes enroll enhancements to TennCare's coverage of pregnant and postpartum women enrolled in TennCare. This notice is provided in order to solicit public input on these planned changes.

TennCare's coverage of pregnant women currently includes approximately 60 days of postpartum coverage following the end of the pregnancy. Effective April 1, 2022, TennCare will provide 12 months of postpartum coverage following the end of pregnancy. Members impacted by this change will continue to be enrolled in managed care and will continue to receive the full TennCare benefits package during their 12 months of postpartum coverage.

Pregnant and postpartum women age 21 and older do not currently receive a dental benefit from TennCare. Effective April 1, 2022, TennCare will provide a dental benefits package for these members for the duration of their pregnancy and postpartum coverage. Dental services for pregnant and postpartum women will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members.

These changes will not result in the enrollment of additional persons in the TennCare program. The extension of TennCare postpartum coverage is expected to result in an increase in annual aggregate expenditures of approximately $20 million under the TennCare program. The addition of a dental benefit for pregnant and postpartum members is expected to result in an increase in annual aggregate expenditures of approximately $6 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents3/ChangeTennCareFFSProgramMaternalHealthEnhancements.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than January 30, 2022.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

• A public hearing will be held electronically on January 5, 2022, at 10:00 a.m. CT. Member of the public interested in attending this hearing may access the event at https://tnaxv.webex.com/tnaxv/j.php?MTID=m3ee0ac0ecc9e0ee0ee0ee0ee0ee0ee0e on the morning of January 5, 2022.

• A public hearing will be held in person on January 6, 2022, at 2:30 p.m. CT in the PEARL Room on the ground floor of the Tennessee Department of Labor and Workforce Development, 220 French Landing Drive in Nashville. Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Tawny Olsen of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. http://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

Notices

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Public Notices

AT&T Mobility, LLC is proposing to construct a 31-foot steel pole telecommunications tower facility located near 6876 Mikayla Lane, Cordova, Shelby County, TN. Any interested party wishing to submit comments regarding the potential effects the proposed facility may have on any historic property may do so by sending comments to: Project 41210105S2 - AMG EBI Consulting, 6876 Susquehanna Trail South, York, PA 17402, or via telephone at (585) 815-3290.

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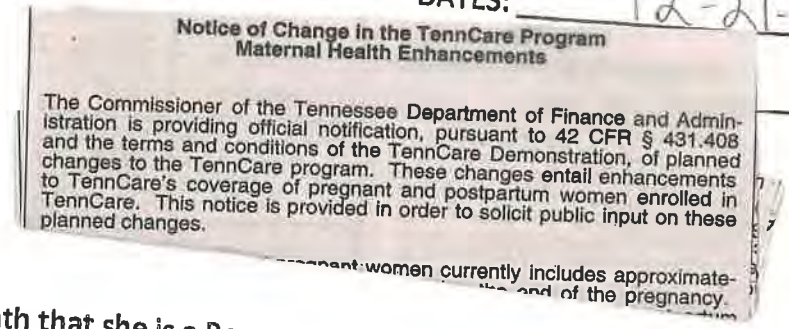
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204 W. Main Street
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AFFIDAVIT OF PUBLICATION

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DATES: 12-21-2021



Notice of Change in the TennCare Program
Maternal Health Enhancements

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes entail enhancements to TennCare's coverage of pregnant and postpartum women enrolled in TennCare. This notice is provided in order to solicit public input on these planned changes.

...pregnant women currently includes approximate... ...end of the pregnancy.

State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oath that she is a Representative of The Johnson City Press , a daily newspaper published in Johnson City, in said County and State, and that the advertisement was published in said paper for 1 Insertion (s) commencing on 12-20-2021 and ending on 12-20-2021

[redacted]

Sworn to and Subscribed before me this 12 21 2021
Month Day Year

[redacted]

RUTH HELMICK
STATE OF TENNESSEE
NOTARY PUBLIC
WASHINGTON COUNTY
MY COMMISSION EXPIRES 11-4-2024

Ruth Helmick
Notary Public

My commission expires on 11/04/2024

This legal notice was published online at www.johnsoncitypress.com and www.publicnoticeads.com during the duration of the run dates listed. This publication fully complies with Tennessee Code Annotated 1-3-20

THE JOHNSON CITY PRESS
204 W. Main Street
Johnson City, TN 37604

AFFIDAVIT OF PUBLICATION

AD# 15.80831

DATES: 12-21-2021

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Carter County)
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Maternal Health Enhancements

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These changes will not result in the enrollment of additional persons in the TennCare program. The extension of TennCare postpartum coverage is expected to result in an increase in annual aggregate expenditures of approximately $20 million under the TennCare program. The addition of a dental benefit for pregnant and postpartum members is expected to result in an increase in annual aggregate expenditures of approximately $6 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/ChangeTennCareIIIProgramMaternalHealthEnhancements.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than January 20, 2022.

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Knoxville NEWS SENTINEL
PART OF THE USA TODAY NETWORK

Attn: Jona
STATE OF TN BUREAU OF TENNCARE
310 GREAT CIRCLE ROAD

NASHVILLE, TN 37243

State of Wisconsin }

County of Brown }

Before me, the undersigned, a Notary Public in and for said county,this d personally came said legal clerk first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of

(The Above-Referenced)

of which the annexed is a copy, was published in said paper in the issues dated:

12/23/2021

and that the statement of account herewith is correct to the best of his/he knowledge, information, and belief.

[redacted]

Legal Clerk

Subscribed and sworn to before me this December 23 2021

[redacted]

Notary

9.19.25

My commission expires

VICKY FELTY
Notary Public
State of Wisconsin

Publication Cost: $293.76
Ad No: 0005057558
Customer No: 1318536

# of Affidavits 1
This is not an invoice

Notice of Change in the TennCare Program
Maternal Health Enhancements

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes entail enhancements to TennCare's coverage of pregnant and postpartum women enrolled in TennCare. This notice is provided in order to solicit public input on these planned changes.

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AFFIDAVIT OF PUBLICATION

0005055466
Newspaper Leaf Chronicle

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

[redacted] Sales Assistant for the above mentioned newspaper,

hereby certify that the attached advertisement appeared in said newspaper on the following dates:

12/23/21

[redacted]

Subscribed and sworn to before me this 23 day of Dec 2021

[redacted]
Notary Public

CHARLY NEEL
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5-7-2024

Affidavits Requested:
1

0005055466NOTICEOFCHANGEINTHETENNCAREPROG
Re: Legal Notice

Classifieds

To advertise, visit:
classifieds.theleafchronicle.com

- Classifieds Phone: **931.552.1234**
- Classifieds Email: **tnclassifieds@gannett.com**
- Public Notices/Legals Email: **publicnotice@tnmedia.com**

All classified ads are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Leaf Chronicle reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Leaf Chronicle shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

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Public Notices

0005055466

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Maternal Health Enhancements

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12/23'21

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0005055954
MaxXx'd Out will sell at auction to satisfy storage lien on the following vehicles on 01/14/2022 at 7:30am:
80 Olds
Vin# 1C3AR47A3EM419511
11 Toyota
Vin# 4T4BF3EK0BR099077
11 Chevrolet
Vin# 1G1ZB5E11BF203469
02 Jeep
Vin# 1J4GL48K12W319226
12 Ford
Vin# 3FAHP0HA5CR245110
Insert Dates: 12/23 & 1/10

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Adopt Me
Pets
all your favorites...
Domestic Pets

Chihauhua, 1Male, 6 Females, 8 weeks old , brown and black , very playful $free (941)218-1582 m.d.grawbarger@gmail.com



Mastiff/Newfoundland, M/F, 7 weeks, apricot/brindle, shots/wormed, farm raised, social $750F/1000M (270)493-1073 diannariddick@gmail.com

Assorted
Merch
all kinds of things...
General Merchandise

VICTORIAN SAND MAJOLICA VASE, w/glazed roses, $50. (620)266-6764 pianog456@gmail.com

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Get started by visiting
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DUE TO EXPANDING BUSINESS WE'RE ADDING TO OUR TEAM! NOW HIRING FOR A FULL-TIME COOK FOR THE O'CONNOR'S TEAM. PREVIOUS EXPERIENCE PREFERRED.
APPLY IN PERSON AT 1198 TYLERTOWN ROAD, TUESDAY - THURSDAY FROM 5:00 TO 7:00PM



JANRIC CLASSIC SUDOKU

Fill in the blank cells using numbers 1 to 9. Each number can appear only once in each row, column and 3x3 block. Use logic and process elimination to solve the puzzle. The difficulty level ranges from Bronze (easiest) to Silver to Gold (hardest).

	2	1		8	3	9		
3				7			2	1
	6		2			5		8
		6			7	2		3
	4			9			1	
1		7	4			8		
9		2			8		5	
6	7			1				2
		8	7	2		1	6	

12/23/21

© 2021 Janric Enterprises Dist. by creators.com

Rating: BRONZE

Solution to 12/22/21

2	3	4	8	1	5	6	9	7
5	6	1	4	7	9	8	2	3
9	8	7	6	2	3	4	5	1
8	9	5	1	4	7	2	3	6
1	4	3	2	9	6	7	8	5
7	2	6	5	3	8	1	4	9
4	5	2	9	6	1	3	7	8
3	1	8	7	5	2	9	6	4
6	7	9	3	8	4	5	1	2

Business & Service Directory

to advertise, email: **ServiceDirectory@theleafchronicle.com** or call: **931.552.1234**

Professional
Service
all your needs...
Business Service

A REPAIRS UNLIMITED
•Carpentry •Drywall
•Roofing •Siding
•Doors •Windows
•Plumbing & Electric.
Call 931-801-7859

Real Estate
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starting fresh...
Commercial

EQUAL HOUSING OPPORTUNITY
Equal Housing Opportunity
All real estate advertising in this newspaper is subject to the Federal Fair Housing Act of 1968 as amended which makes it illegal to advertise "any preferences, limitation, or discrimination based on race, color, religion, sex, handicap, familial status or nation origin, or an intention to make any such preference, limitation or discrimination.
"This newspaper will not knowingly accept any advertisement for real estate which is in violation of the law. Our readers are hereby informed that all dwellings advertised in this newspaper area available on an equal opportunity basis. To complain of discrimination, call HUD Toll-free at 1-800-669-9777. For hearing impaired call 1-800-927-9275.

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✔ Decks ✔ Fencing
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We're the Business that Does Small Jobs & Repairs!!
• Textured Ceilings
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• Taping • Finishing
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Wanted:
A desk plate, not a nametag.
Find what you want in
The Leaf-Chronicle Classifieds.

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Check out your local classifieds today.



AFFIDAVIT OF PUBLICATION

0005055458
Newspaper The Tennessean

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

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12/23/21

[redacted]

Subscribed and sworn to before me this 23 day of Dec 2021

[redacted]
Notary Public

CHARLY NEEL
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5-7-2024

Affidavits Requested:
1

0005055458NOTICEOFCHANGEINTHETENNCAREPROG
Re: Legal Notice

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0005055458

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12/23'21

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615-394-3498

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jobs.tennessean.com



49% of business
owners want a

STATE OF TENNESSEE
COUNTY OF OBION

Personally appeared before me, the undersigned Notary Public for Obion County Tennessee, David CRITCHLOW, who on oath says he is the publisher of the Union City Daily Messenger a daily newspaper of general circulation, published at Union City in said county and state, and that the hereto attached

Notice

Notice was published in said paper for 1 ~~consecutive days~~ as follows:

12/21, _____, _____, _____, 2021

Publisher [redacted]

Publisher's Fee $ 322.38

Subscribed and sworn to before me this 28th day of December 2021

Notary Public [redacted]

DONNA L. GIBSON
STATE OF TENNESSEE NOTARY PUBLIC
OBION COUNTY

CLASSIFIEDS

Misc. For Sale • Services • Real Estate • Help Wanted

Misc. For Sale

FOR SALE:
Graco Magnum 262805
X7 Cart Airless
Paint Sprayer
NEW in box, Never used,
Paid $390 asking $250
Text only 731-446-5088



Notice

NOTICE
The Messenger screens all classified ads prior to publishing in order to protect our readers from scams.

Our customers are important to us. If you see an ad that you are unsure of or if you respond to an ad that is a scam, please contact us.

The Messenger Classifieds Department 731-885-0744

Legal

SUBSTITUTE TRUSTEE'S SALE
Sale at public auction will be on January 11, 2022 on or about 2:00PM local time, At the East Door of the, Obion County Courthouse, Bill Burnett Circle, Union City, TN 38261, conducted by the Substitute Trustee as identified and set forth herein below, pursuant to Deed of Trust executed by MARY VIRGINIA RICE, to Jon M. Dickerson, Trustee, on November 10, 1993, at Record Book 51-G, Page 73-79 in the real property records of Obion County Register's Office, Tennessee.
Owner of Debt: Specialized Loan Servicing LLC
The following real estate located in Obion County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:
Beginning at a mark in the south side of a concrete sidewalk on the south side of High Street, said mark being the Northwest corner of a lot belonging to Barkley and being over a drain under said walk, said mark also being in the south margin of High Street and being 88.1 feet west of the face of the west curb of Clover Street; thence, South 05 deg. 28 min 58 sec West, with the west line of Barkley, for a distance of 123.30 feet to an iron pin; thence, North 84 deg. 40 min. 00 sec. West, making a new line through Lane, for a distance of 86.00 feet to an iron pin in the east line of a lot belonging to Reithel; thence, North 05 deg. 28 min. 58 sec. East, with the ease tine of Reithel, for a distance of 123.30 feet to an iron pin at the northeast corner of Reithel, said pin also being in the south margin of High Street and being at the intersection of the back of a concrete sidewalk with the west edge of a concrete driveway; thence, South 84 deg. 40 min. 00 sec. East, with the south margin of High Street and the back of said walk, for a distance of 86.00 feet to the point of beginning, and containing 10,604 square feet or 0.243 acres, according to a survey by Robert L. Nichols, TN RLS No. 1009, on October 7, 1993, with all bearings based upon Magnetic North.
Being the same property conveyed to Mary Virginia Rice by Tony R. Lane and Melissa G. Lane by Warranty Deed recorded 11-11-93, deed book 22V page 390, in the register`s office of Obion County, Tennessee.
Tax ID: 048M-D-009.00-000
Current Owner(s) of Property: MARY VIRGINIA RICE
The street address of the above described property is believed to be 815 E High Street, Union City, TN 38261, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO OCCUPANT(S) RIGHTS IN POSSESSION.
THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TERMS OF SALE ARE CASH. ANY TAXES OR FEES WILL BE THE RESPONSIBILITY OF THE PURCHASER. IF THE SALE IS SET ASIDE FOR ANY REASON, THE PURCHASER AT THE SALE SHALL BE ENTITLED ONLY TO A RETURN OF THE PURCHASE PRICE. THE PURCHASER SHALL HAVE NO FURTHER RECOURSE AGAINST THE GRANTOR, THE GRANTEE, OR THE TRUSTEE.
OTHER INTERESTED PARTIES: None
THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.
If applicable, the notice requirements of T.C.A. 35-5-101 have been met.
All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, but the undersigned will sell and convey only as Substitute Trustee.
If the U.S. Department of Treasury/IRS, the State of Tennessee Department of Revenue, or the State of Tennessee Department of Labor or Workforce Development are listed as Interested Parties in the advertisement, then the Notice of this foreclosure is being given to them and the Sale will be subject to the applicable governmental entities' right to redeem the property as required by 26 U.S.C. 7425 and T.C.A. §67-1-1433.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. If the sale is set aside for any reason, the Purchaser at the sale shall be entitled only to a return of the purchase price. The Purchaser shall have no further recourse against the Mortgagor, the Mortgagee or the Mortgagee's attorney.
MWZM File No. 21-000057-370-1
Mackie Wolf Zientz & Mann, P.C., Substitute Trustee(s)
COOL SPRINGS COMMONS, SUITE 273
7100 COMMERCE WAY
BRENTWOOD, TN 37027
TN INVESTORS PAGE: HTTP://MWZMLAW.COM/TN_INVESTORS.PHP
12/7/2021, 12/14/2021, 12/21/2021

IN THE CHANCERY COURT OF OBION COUNTY, TENNESSEE AT UNION CITY
CRYSTAL NANCE,
Petitioner
VS.
REGINALD NANCE,
Respondent
Case No. 33,261
ORDER OF PUBLICATION
In the above styled cause, it appearing to the Clerk and Master from the sworn Petition to Modify Permanent Parenting Plan and Child Support with Petition for Civil Contempt filed in this cause, that the whereabouts of Reginald Nance, respondent, are unknown.
IT IS THEREFORE hereby ordered that the above named respondent serve upon Honorable Eric P. Egbert, 115 West Court Square, Trenton, TN 38382, Attorney for Petitioner, an answer to this Petition within 30 days from the last date of publication and also file a copy of answer with the Clerk and Master of the Chancery Court of Union City, Tennessee, and make defense to said Petition, or the same will be taken as confessed by petitioner, and the cause set for hearing ex parte as to the respondent.
IT IS FURTHER ORDERED that publication of this notice be made for four consecutive weeks in the Union City, Daily Messenger, a daily newspaper published in Obion County, Tennessee.
This 23rd. day of November, 2021.
PAULA RICE
Clerk & Master
Eric P. Egbert
Attorney
11/30/2021, 12/7/2021, 12/14/2021, 12/21/2021

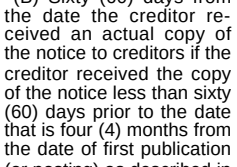
Messenger Classifieds 731-885-0744

NOTICE
Notice is hereby given that a meeting of The Industrial Development Board of the City of Union City, Tennessee ("Board") will be held on December 28, 2021 at 10:00 a.m. in the City Council meeting room of the Municipal Building in Union City, Tennessee. The purpose of the meeting is: (a) to approve an increase in the previously approved payment in lieu of taxes ("PILOT") transaction to an amount not to exceed $125,000,000 in order to acquire real property, improvements thereto, equipment and other personal property to be used at the Tyson Foods, Inc. facility located at 4667 Knox Daniel Road, Union City, Tennessee, and to approve related documents necessary to consummate the acquisition of said property and the lease thereof to Tyson Foods, Inc.; (b) to approve an increase in the previously approved payment in lieu of taxes ("PILOT") transaction to an amount not to exceed $10,000,000 in order to acquire real property, improvements thereto, equipment and other personal property to be used at the Institutional Casework Incorporated facility located at 503 East Reelfoot Ave., Union City, Tennessee, and to approve related documents necessary to consummate the acquisition of said property and the lease thereof to Tyson Foods, Inc., and (c) such other matters as may come before the Board.
This 21st Day of December, 2021.
Bedford F. Dunavant, IV, Chairman
12/21/2021

NOTICE TO CREDITORS
34,943
ESTATE OF
Hubert Vernon Alexander Jr
Deceased
Notice is hereby given that on the 15th day of December, 2021, Letters Testamentary in respect of the estate of Hubert Vernon Alexander Jr who died October 7th, 2021 were issued to the undersigned by the Chancery Court of Obion, County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured, against the estate are required to file the same with the Clerk of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1)
(A) Four (4) months from the date of the first publication (or posting as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or
(2) Twelve (12) months from the decedent's date of death,
This 16th day of December, 2021
Virginia Alexander
Personal Representative
Attorney for the Estate
Mark D. Johnston
Paula Rice
Clerk and Master
12/21/2021, 12/28/2021

NOTICE TO CREDITORS
34,937
ESTATE OF
Doris Hardesty
Notice is hereby given that on the 9th day of December, 2021, Letters Administration in respect of the estate of Doris Hardesty who died December 1st, 2021 were issued to the undersigned by the Chancery Court of Obion, County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured, against the estate are required to file the same with the Clerk of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1)
(A) Four (4) months from the date of the first publication (or posting as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or
(2) Twelve (12) months from the decedent's date of death,
This 10th day of December, 2021
Deborah Ams
Personal Representative
Attorney for the Estate
Randy M. Chism
Paula Rice
Clerk and Master
12/14/2021, 12/21/2021

Notice of Change in the TennCare Program Maternal Health Enhancements
The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes entail enhancements to TennCare's coverage of pregnant and postpartum women enrolled in TennCare. This notice is provided in order to solicit public input on these planned changes.
TennCare's coverage of pregnant women currently includes approximately 60 days of postpartum coverage following the end of the pregnancy. Effective April 1, 2022, TennCare will provide 12 months of postpartum coverage following the end of pregnancy. Members impacted by this change will continue to be enrolled in managed care and will continue to receive the full TennCare benefits package during their 12 months of postpartum coverage.
Pregnant and postpartum women age 21 and older do not currently receive a dental benefit from TennCare. Effective April 1, 2022, TennCare will provide a dental benefits package for these members for the duration of their pregnancy and postpartum coverage. Dental services for pregnant and postpartum women will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members.
These changes will not result in the enrollment of additional persons in the TennCare program. The extension of TennCare postpartum coverage is expected to result in an increase in annual aggregate expenditures of approximately $20 million under the TennCare program. The addition of a dental benefit for pregnant and postpartum members is expected to result in an increase in annual aggregate expenditures of approximately $6 million under the TennCare program.
The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/ChangeTennCareIIIProgramMaternalHealthEnhancements.pdf.
Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than January 20, 2022.
Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:
• A public hearing will be held electronically on January 5, 2022, at 10:00 a.m. CT. Member of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of January 5, 2022.
• A public hearing will be held in person on January 6, 2022, at 2:30 p.m. CT in the PEARL Room on the ground floor of the Tennessee Department of Labor and Workforce Development, 220 French Landing Drive in Nashville.
Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.
Copies of this notice will be available in each county office of the Tennessee Department of Health.
We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html
12/21/2021



NOTICE TO CREDITORS
34,938
ESTATE OF
Diana K. Cathey
Notice is hereby given that on the 9th day of December, 2021, Letters Testamentary in respect of the estate of Diana K. Cathey who died November 7th, 2021 were issued to the undersigned by the Chancery Court of Obion, County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured, against the estate are required to file the same with the Clerk of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1)
(A) Four (4) months from the date of the first publication (or posting as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or
(2) Twelve (12) months from the decedent's date of death,
This 10th day of December, 2021
Christina K. Cook
Personal Representative
Attorney for the Estate
Hal Warren
Paula Rice
Clerk and Master
12/14/2021, 12/21/2021

LEGAL NOTICE
IT IS THE DUTY OF YOUR GRAND JURORS TO INVESTIGATE ANY PUBLIC OFFENSE WHICH THEY KNOW OR HAVE REASON TO BELIEVE HAS BEEN COMMITTED AND WHICH IS TRIABLE OR INDICTABLE IN THIS COUNTY. ANY PERSON HAVING KNOWLEDGE OR PROOF THAT AN OFFENSE HAS BEEN COMMITTED MAY APPLY TO TESTIFY BEFORE THE GRAND JURY SUBJECT TO TENNESSEE CODE ANNOTATED, SECTION 40-12-105.
THE FOREMAN IN THIS COUNTY IS PRESENTLY: ROBERT WARD BUSHART OF 5645 COUNTRY CLUB RD., SOUTH FULTON, TN 38257.
THE GRAND JURY WILL NEXT MEET ON TUESDAY, THE 1st DAY OF FEBRUARY 2022, AT





Attachment D

Public Comments

January 20, 2022

Aaron Butler, Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, Tennessee 37243
Emailed to: public.notice.tenncare@tn.gov

Re: TennCare III Enhancements

Dear Mr. Butler:

The Tennessee Association of Mental Health Organizations (TAMHO) is grateful for the opportunity to comment on the planned changes to the TennCare III Project. TAMHO is the state trade association representing Community Mental Health Centers and other nonprofit behavioral health providers. Our members are the cornerstone of the TennCare provider network for those with the most complex mental health, substance use, co-occurring and co-morbid needs.

Extension of Postpartum Coverage

TAMHO commends TennCare for the planned TennCare III change to extend postpartum coverage from 60 days to 12 months starting April 1, 2022. While giving birth can be the happiest time of a woman's life, it can also be one of the most stressful times. We are grateful that TennCare is extending its full benefit package that includes behavioral health services to this population. TAMHO and its member organizations ask to work with TennCare to identify the health needs of this population so that appropriate prevention and treatment services can be provided when indicated. We truly believe in a whole-person health approach and know that when mothers are healthy, they are better able to care for their babies and families.

Addition of Dental Coverage for Pregnant and Postpartum

Thank you for including dental benefits for pregnant and postpartum women who are 21 and older to the planned change to TennCare III. Oral health is crucial to overall health, especially for pregnant women where conditions like gum disease can increase the likelihood of preterm births. TAMHO member organizations play an important role in coordinating the care for these women and look forward to working with TennCare to achieve greater health outcomes.

If you have any questions or would like to schedule a time to discuss how our member organizations can help assist with the healthcare needs of both mother and child, please feel free to contact Ellyn Wilbur, Executive Director, at 615-244-2220 or ewilbur@tamho.org or me at the information shown.

Thank you for your time and consideration.

P.O. Box 1274
Brentwood, Tennessee 37024

www.tamho.org

(615) 244-2220
(800) 568-2642 toll free in TN

Sincerely,

[redacted]

Alysia Smith Knight
Director of Policy and Advocacy
Tennessee Association of Mental Health Organizations

CC: Stephen Smith, Deputy Commissioner and Director of TennCare
Mary Shelton, Director, Behavioral Health Operations, TennCare

January 19, 2022

ATTN: TennCare
Aaron Butler, Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Sent via electronic mail to: public.notice.tenncare@tn.gov

RE: Notice of Change to the TennCare III Program Maternal Health Enhancements

Dear Mr. Butler,

The American Heart Association (AHA) appreciates your time and attention and this opportunity to submit comments on the Notice of Change to the TennCare III Program Maternal Health Enhancements.

The AHA believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. As the nation's oldest and largest organization dedicated to fighting heart disease and stroke, the AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care. Nationally, about 1 in 10 adults with Medicaid coverage are estimated to have some form of CVD, with 6 in 10 having multiple chronic conditions.[1]

CVD is the leading cause of maternal mortality in the U.S., accounting for over a third of pregnancy-related deaths.[2,3] Despite major advances in science and medicine that have reduced pregnancy-related deaths in other countries, the number of overall cardiovascular deaths in the pregnant and postpartum population has continued to increase in the U.S. over the past 20 years.[4] Multiple studies have shown lack of insurance and inability to pay for care are major barriers to accessing prenatal and postpartum care in the U.S.[5]

For this patient population that is already at a high risk of experiencing CVD, it is especially important pregnant and postpartum Medicaid patients have regular, continuous care during pregnancy and for at least the year following delivery. Expanding access to Medicaid has been shown to reduce maternal mortality, particularly benefiting racial and ethnic minorities, likely through reduced insurance turn-over rates, improved postpartum access to care, and improved care between pregnancies.[6] Extending Medicaid coverage for one year after delivery would provide many benefits to women and their families by covering critical needs related to pregnancy, childbirth and breast-feeding, chronic conditions, mental health, and other needs.

The American Heart Association enthusiastically supports Tennessee's proposed changes to the TennCare III Program. Specifically, the AHA supports the guarantee of full Medicaid benefits—to include coverage for all healthcare services—for the duration of pregnancy and throughout the 12-month postpartum period. We know this augmented access to care will be critical to identification and treatment of pregnancy-related CVD and other postpartum health and mental health issues—all of which can have multigenerational health impacts on families and communities. We hope TennCare plans to and is able to make this a permanent change to the state's Medicaid program to benefit generations of Tennesseans to come.

Thank you for working alongside the American Heart Association in support of longer, healthier lives for all.

Sincerely,

Leanne Durm-Minoux

Leanne Durm-Minoux
Tennessee Government Relations Director

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[1] Chapel, JM, Ritchey MD, Zhang D, Wang G. Prevalence and medical costs of chronic diseases among adult Medicaid beneficiaries. *AJPM*. 2017: 53(6);S143-S154.

[2] Centers for Disease Control and Prevention: Reproductive Health, https://www.cdc.gov/reproductivehealth/index.html

[3] Creanga AA, Syverson C, Seed K and Callaghan WM. Pregnancy-Related Mortality in the United States, 2011-2013. *Obstet Gynecol*. 2017;130:366-373.

[4] Creanga AA, Syverson C, Seed K and Callaghan WM. Pregnancy-Related Mortality in the United States, 2011-2013. *Obstet Gynecol*. 2017;130:366-373.

[5] Phillippi JC. Women's perceptions of access to prenatal care in the United States: a literature review. *J Midwifery Womens Health*. 2009;54(3):219-225. doi:10.1016/j.jmwh.2009.01.002

[6] Luther JP, Johnson DY, Joynt Maddox KE, Lindley KJ. Reducing cardiovascular maternal mortality by extending Medicaid for postpartum women. *JAHA*. 2021; 10(15):e022040.

January 20, 2022

VIA ELECTRONIC SUBMISSION

Aaron Butler, Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: Proposed Maternal Health Enhancements to TennCare III Program

Dear Director Butler:

The undersigned organizations appreciate the opportunity to comment on the January 6, 2022 Notice of Change to the TennCare III Program relating to postpartum coverage. We strongly support the extension of postpartum coverage for 12 months following the end of pregnancy, but we urge the state not to impose cost sharing on prescription drugs during the postpartum period. We also urge the state to extend postpartum coverage through a State Plan Amendment rather than the TennCare III waiver. In addition, we strongly support the state's proposal to provide dental benefits to pregnant and postpartum women.

Extending Medicaid coverage through 12 months postpartum will improve maternal health outcomes for an estimated 22,000 new mothers in Tennessee each year.

Tennessee has provided notice that, effective April 1, 2022, it will provide 12 months of postpartum coverage following the end of pregnancy. According to estimates by the Assistant Secretary for Planning and Evaluation, this will benefit about 22,000 new mothers in Tennessee each year, reducing their risk of untreated postpartum depression, unaddressed opioid use disorder, and pregnancy-related death.[1] We strongly support this policy change.

Imposing cost sharing on prescription drugs during the postpartum period will create a barrier to access to needed medications, increasing the risk of poor maternal health outcomes.

Tennessee's notice states that during the extended period of postpartum coverage pregnant women "may be subject to nominal copays for prescription drugs." Imposition of cost sharing on postpartum women would undermine the maternal health benefits of extended coverage and be inconsistent with current federal requirements.

The research is clear that cost sharing is a barrier to access for low-income populations. A 2021 Kaiser Family Foundation research review of evidence from Medicaid 1115 waivers on the effects of cost sharing and premiums on Medicaid beneficiaries concluded that cost sharing is "associated with

[1] Gordon, S. *et al.* "Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage," (Washington: Assistant Secretary for Planning and Evaluation, December 7, 2021), available at https://aspe.hhs.gov/sites/default/files/documents/cf9a715be16234b80054f14e9c9c0d13/medicaid-postpartum-coverage-ib%20.pdf#page=16.

reduced use of care, worse health outcomes, and increased financial burden."[2] There is every reason to think that these conclusions apply to pregnant women during the postpartum period. Consider those women with postpartum depression, among the most common complications of pregnancy. According to the American College of Obstetrics and Gynecologists, prescription anti-depressants, along with talk therapy, are an effective treatment.[3] Imposing cost sharing requirements on these drugs during the postpartum period will reduce their use by women who need them, leading to worse maternal health outcomes.

Under current Medicaid law, pregnant women are exempted from copayments on all services through the 60-day postpartum period, except for services specified in the State Plan as "not pregnancy-related."[4] These regulations were adopted before the enactment of the State Plan option to extend coverage through 12 months postpartum, and CMS has not yet issued guidance on the application of this exemption beyond 60 days. However, the state need not await CMS guidance. The reasons the State exempts women from cost sharing on prescription drugs during the first 60 days postpartum are equally applicable during the remainder of the 12-month postpartum period: improved access to prescription drugs for conditions like postpartum depression, better health outcomes, and decreased financial burden.

Extending dental coverage to pregnant women through the 12-month postpartum period will improve maternal health outcomes.

Tennessee has provided notice that, as of April 1, 2022, it will provide a dental benefits package for pregnant women for the duration of their pregnancy and postpartum coverage. We strongly support this policy change. It will improve oral health outcomes for both the mother and the baby. The American College of Obstetricians and Gynecologists recommends oral health care throughout a woman's lifespan, including during pregnancy when women may be at higher risk for periodontal disease and cavities; improved oral health of pregnant women "may decrease transmission of potentially cariogenic bacteria to infants and reduce children's future risk of caries."[5]

Tennessee should extend postpartum coverage through 12 months without cost sharing, and extend dental benefits to pregnant women through the postpartum period, by amending its State Plan.

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[2] Guth, M., Ammula, M., and Hinton, E. "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers," (Washington: The Henry J. Kaiser Family Foundation, September 9, 2021), available at https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

[3] "FAQs: Postpartum Depression," American College of Obstetricians and Gynecologists, available at https://www.acog.org/womens-health/faqs/postpartum-depression.

[4] 42 CFR 447.56(a)(1)(vii).

[5] American College of Obstetricians and Gynecologists Committee Opinion, "Number 569: Oral Health Care During Pregnancy and Through the Lifespan," (August 2013), available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan. See also: Daalderop, L.A. *et al.,* "Periodontal Disease and Pregnancy Outcomes: Overview of Systematic Reviews," *JDR Clinical & Translational Research* 3, no. 1 (January 2018): 10-17, available at https://doi.org/10.1177/2380084417731097; and Finlayson, T., Gupta, A., and Ramos-Gomez, F., "Prenatal Maternal Factors, Intergenerational Transmission of Disease, and Child Oral Health Outcomes," *Dental Clinics of North America* 61, no. 3 (2017): 483-513, available at https://doi.org/10.1016/j.cden.2017.02.001.

Tennessee's January 6 notice indicates that the changes to pregnancy and postpartum coverage are being made under the terms of the TennCare III Demonstration. STC #6 permits the state to "add allowable benefits and coverage" without submitting an amendment to the Demonstration to CMS. We believe this procedural pathway puts these changes at unnecessary risk and urge the state to effect these changes by amending its State Plan.

The State Plan option is available for both sets of changes. The American Rescue Plan Act of 2021 (P. L. 117-2) gives states the option of providing 12 months of extended postpartum coverage to pregnant women enrolled in Medicaid beginning April 1, 2022.[6] CMS has provided detailed guidance on how states can submit State Plan Amendments to take up the option.[7] Similarly, federal regulations at 42 CFR 440.255(p) allow to provide "a greater amount, duration, or scope of services to pregnant women" than it provides to other groups of beneficiaries. Thus, Tennessee could extend a package of dental benefits to pregnant women through the postpartum period through a SPA, without the need for a waiver of comparability.

These State Plan options are on firm legal ground. The TennCare III Demonstration is not. Its "shared savings" financing, closed formulary, and 10-year duration are provisions that the Secretary does not have the authority to approve. We believe that the litigation currently pending against TennCare III will result in fundamental revisions to the Demonstration. Putting these changes at legal risk by tying them to TennCare III is both unnecessary and unwise.

Thank you for your consideration of these comments. If you need additional information, please contact Joan Alker (jca25@georgetown.edu).

American College of Obstetricians and Gynecologists
American Lung Association
Black Mamas Matter Alliance
Center for Law and Social Policy
Center for Reproductive Rights
Community Catalyst
Equitable Maternal Health Coalition
Families USA
First Focus on Children
Georgetown University Center for Children and Families
March of Dimes
Maternal Mental Health Leadership Alliance
Mental Health America
National Association of Pediatric Nurse Practitioners
National Birth Equity Collaborative
National Health Care for the Homeless Council
National Multiple Sclerosis Society
National Partnership for Women & Families
Planned Parenthood Federation of America

[6] P. L. 117-2 (2021).
[7] Center for Medicaid and CHIP Services, "SHO #21-007: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP)," (December 2021), available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.

Primary Care Development Corporation
SisterReach
Tennessee Academy of Family Physicians
United Way Worldwide

Division of TennCare

July 29, 2022

April Wiley
State Demonstrations Group
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-26-06
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Notice of Change to Coverage and Benefits under the TennCare Demonstration

Dear Ms. Wiley,

Pursuant to the terms and conditions of the TennCare Demonstration, Tennessee is providing official notice to CMS of our intent to make changes to coverage and benefits available under the Demonstration. These changes add allowable benefits and coverage, as permitted by the Demonstration's STCs.

Specifically, Tennessee plans to re-open the CHOICES At Risk Demonstration Group to new enrollment, up to an enrollment target of 1,750 new enrollees. This change is scheduled for implementation beginning October 1, 2022. The CHOICES At Risk Demonstration Group will continue to operate in a manner consistent with the approved authorities in the TennCare demonstration.

We are pleased to be able to make this enhancement to the coverage available under TennCare. This change will allow TennCare to provide supports to elderly persons and persons with disabilities at risk of institutionalization.

A fuller description of this change is attached to this letter. In addition, we have attached documentation of the state's compliance with the public notice requirements outlined in the Demonstration's STCs.

If you have any questions about this notice or if you need additional information, please contact Aaron Butler at 615.507.6448, or aaron.c.butler@tn.gov.

Sincerely,

[redacted]

Stephen Smith
Director, Division of TennCare

Attachments

Attachment A

Description of Changes to Coverage and Benefits

Description of Changes to Coverage and Benefits

The following provisions related to coverage and benefits under the TennCare Demonstration will become effective on October 1, 2022.

Open the CHOICES At Risk Demonstration Group to New Enrollment. The CHOICES At Risk Demonstration Group is a demonstration population within the TennCare demonstration that covers persons who are not otherwise eligible for Medicaid and who, absent CHOICES services and supports, are at risk for institutionalization.

To qualify for TennCare in the CHOICES At Risk Demonstration Group, individuals must meet the following criteria:

1. Be age 65 or older, or be age 21 and older with physical disabilities;
2. Meet TennCare's financial eligibility standards for individuals receiving institutional care (income no more than 300 percent of the SSI federal benefit rate, resources no more than $2,000); and
3. Would, in the absence of CHOICES services and supports, be at risk of institutionalization consistent with TennCare's level of care criteria for CHOICES Group 3.

Individuals enrolled in the CHOICES At Risk Demonstration Group receive all covered TennCare benefits for adults. In addition, individuals enrolled in the CHOICES At Risk Demonstration Group receive CHOICES Group 3 home- and community-based services, as specified in the special terms and conditions of the TennCare demonstration. Like all TennCare enrollees, individuals in the CHOICES At Risk Demonstration Group are enrolled in managed care for receipt of their TennCare benefits (including their CHOICES Group 3 benefits). The CHOICES At Risk Demonstration Group and CHOICES Group 3 will continue to operate in a manner consistent with the approved authorities in the TennCare demonstration.

The CHOICES At Risk Demonstration Group will be opened to new enrollment effective October 1, 2022, up to an enrollment target of 1,750 new individuals enrolled in the group.

Attachment B

Description of Public Notice and Input

Description of Public Notice and Input

Effective October 1, 2022, the CHOICES At Risk Demonstration Group will be opened to new enrollment. TennCare has taken a variety of steps to ensure that members of the public have been notified of this planned change and have had an opportunity to provide comments and input. These measures were informed by—and comply with—the STCs of the TennCare Demonstration and 42 CFR § 431.408.

Public Notice

The state held a formal notice and comment period on this proposed change to coverage and benefits from June 8, 2022, through July 8, 2022. During this time, a comprehensive description of the planned change was made available for public review and comment on a designated page on the TennCare website. An abbreviated public notice—which included a summary description of the planned change; the locations, dates, and times of two public hearings; and a link to the full public notice on the state's website—was published in the newspapers of widest circulation in Tennessee communities with 50,000 or more residents.

The state held two public hearings to seek public comment on this planned change to TennCare coverage. One hearing took place on June 22, 2022, at 2:00 p.m., Central Time, at the PEARL Meeting Room at the Tennessee Department of Labor & Workforce Development, 220 French Landing Drive, Nashville, Tennessee. The second hearing was conducted virtually and took place on June 23, 2022, at 10:00 a.m., Central Time. Members of the public also had the option to submit comments throughout the notice period by mail and/or email.

In addition, this planned change was presented as a funding request by TennCare during the 2022 session of the Tennessee General Assembly and were approved by the General Assembly as part of the state budget through a public legislative process.

In addition, TennCare disseminated information about this proposed change, including a link to the relevant information on TennCare's website, via its social media accounts (i.e., Facebook, Twitter).

Public Comments

TennCare received five sets of comments on this proposed change from individuals or organizations, either in writing or at one of the public hearings. These comments are summarized below. In addition, comments received in writing are attached in their entirety as Attachment D.

TennCare received comments from one organization indicating support for re-opening enrollment in the CHOICES At Risk Demonstration Group. This organization noted the benefits that making CHOICES Group 3 HCBS will have for elderly individuals and individuals with disabilities in Tennessee. This commenter expressed concern that the state's proposed enrollment target of 1,750 persons might be insufficient to meet the needs of all individuals at risk for institutionalization in Tennessee. This

commenter further expressed concerns about the acuity scale used by the state to evaluate individuals' functional needs.

TennCare thanks this commenter for their support for re-opening enrollment in CHOICES Group 3. We agree that re-opening enrollment in the CHOICES At Risk Demonstration Group will have positive impacts for individuals in Tennessee who are currently at risk of institutionalization. Enrollment targets have long been a feature of the CHOICES program and of Medicaid HCBS programs generally. The proposed enrollment target of 1,750 is based on currently available appropriations. Once these program slots have been filled, TennCare will evaluate the extent to which additional demand remains and may modify the enrollment target, subject to future appropriations. Currently, TennCare has no plans to change the way that level of care (LOC) needs for CHOICES are assessed; however, the state appreciates this commenter's input and will take it into consideration if changes to the LOC process are considered in the future.

TennCare received several comments from individuals suggesting that the eligibility criteria for CHOICES be broadened to provide supports for persons with disabilities but who do not meet the state's current level of care criteria for CHOICES.

TennCare appreciates these commenters' input. Re-opening enrollment in CHOICES Group 3 will provide an opportunity for individuals with lower levels of functional need (i.e., those who do not meet the state's level of care criteria for nursing facility care but who are assessed to be "at risk" of institutionalization) to access CHOICES services and supports. TennCare will continue to work with stakeholders to monitor the criteria used for CHOICES eligibility to ensure they reflect as accurately as possible applicants' level of need.

Attachment C

Documentation of Public Notice

Notice of Change to the TennCare III Program
CHOICES At Risk Demonstration Group (Group 3)

Published June 8, 2022

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of planned changes to the TennCare program. These changes entail opening enrollment in a demonstration population known as the CHOICES At Risk Demonstration Group. TennCare is publishing this notice pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration in order to solicit public input on this planned change.

Description of Planned Program Changes

Within the TennCare Demonstration, the CHOICES program provides managed long-term services and supports (MLTSS) for persons who are elderly or who have physical disabilities. CHOICES consists of three benefit groups:

> **CHOICES Group 1** consists of individuals who meet TennCare's level of care criteria for nursing facility care and who are receiving LTSS in a nursing facility.
>
> **CHOICES Group 2** consists of adults who meet TennCare's level of care criteria for nursing facility care and who are receiving home- and community-based services (HCBS) in lieu of nursing facility care.
>
> **CHOICES Group 3** consists of adults who do not meet TennCare's level of care criteria for nursing facility care but who, absent additional supports, are considered at risk of needing institutional care. These individuals receive a targeted package of HCBS intended to prevent or delay the need for nursing facility care.

Under the terms of the TennCare Demonstration, CHOICES Group 3 is open to individuals who are eligible for Medicaid as SSI recipients and to non-Medicaid-eligible individuals who qualify in the CHOICES At Risk Demonstration Group. The purpose of the CHOICES At Risk Demonstration Group is to provide a pathway for individuals who are not otherwise eligible for Medicaid to be eligible for TennCare and to receive CHOICES Group 3 HCBS.[1]

[1] The TennCare Demonstration refers to the benefits received by Medicaid-eligibles as "CHOICES 3" and the benefits received by Demonstration-eligibles as "Interim CHOICES 3." However, the benefits are the same in both cases. For simplicity, this notice uses the terms "CHOICES 3" and "Interim CHOICES 3" synonymously.

The CHOICES At Risk Demonstration Group has been closed to new enrollment since June 30, 2015.

In this notice, Tennessee is providing official notification that TennCare intends to re-open new enrollment in the CHOICES At Risk Demonstration Group, up to an enrollment target of 1,750 new enrollees. This change will become effective on October 1, 2022. Note that this enrollment target only applies to individuals eligible for TennCare in the CHOICES At Risk Demonstration Group; individuals eligible for Medicaid as SSI recipients who qualify for CHOICES Group 3 benefits will not count against this enrollment target.

To qualify for TennCare in the CHOICES At Risk Demonstration Group, individuals must meet the following criteria:

1. Be age 65 or older, or be age 21 and older with physical disabilities;
2. Meet TennCare's financial eligibility standards for individuals receiving institutional care (income no more than 300 percent of the SSI federal benefit rate, resources no more than $2,000); and
3. Would, in the absence of CHOICES services and supports, be at risk of institutionalization consistent with the state's existing level of care criteria for CHOICES Group 3.

Individuals enrolled in the CHOICES At Risk Demonstration Group receive all covered TennCare benefits for adults. In addition, individuals enrolled in the CHOICES At Risk Demonstration Group receive CHOICES HCBS, not to exceed $18,000 per calendar year, as follows:

- Short-term nursing facility services (up to 90 days per stay)
- Community-based residential alternative services (CBRAs)[2]
- Attendant care (up to 1,080 hours per calendar year); up to 1,400 hours per calendar year ONLY when homemaker services are needed in addition to hands-on care
- Home-delivered meals (up to 1 meal per day)
- Personal Emergency Response System
- Adult day care (up to 2,080 hours per calendar year)

[2] CBRAs available in CHOICES Group 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 individual's $18,000 expenditure cap, 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.

- In-home respite care (up to 216 hours per calendar year)
- Inpatient respite care (up to 9 days per calendar year)
- Assistive technology (up to $900 per calendar year)
- Enabling technology (up to $5,000 per calendar year)[3]
- Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)[4]
- Pest control (up to 9 units per calendar year)

For more information about CHOICES benefits, see Table 2b, Attachment E, and Attachment S of the TennCare Demonstration.

Expected Impact on Enrollment and Expenditures

Re-opening the CHOICES At Risk Demonstration Group to new enrollment is expected to result in an increase in enrollment in the TennCare Demonstration of approximately 1,750 persons. This change is expected to result in an increase in annual aggregate expenditures under the TennCare program of approximately $58.8 million.

Evaluation Impact

TennCare does not anticipate modifying its evaluation design based on these planned changes. These changes are expected to contribute to key goals of the TennCare Demonstration already reflected in the demonstration's evaluation design (currently under CMS review). These include enhancing coverage and benefits available under the TennCare Demonstration and supporting access to appropriate and cost-effective HCBS.

Waiver and Expenditure Authorities Requested

TennCare is not requesting any new waiver or expenditure authorities under Section 1115 of the Social Security Act to implement these changes. The CHOICES At Risk Demonstration Group is already an approved part of the TennCare Demonstration, which provides 1115(a)(2) expenditure authority to provide Medicaid benefits, including CHOICES Group 3 HCBS, to individuals enrolled in the CHOICES At Risk Demonstration Group. The CHOICES At

[3] The CHOICES program's Enabling Technology benefit is funded in part with federal funds authorized under Section 9817 of the American Rescue Plan Act. Currently, states may spend these funds until March 31, 2025. Accordingly, Enabling Technology is currently a covered benefit under CHOICES until March 31, 2025.

[4] The cost of minor home modifications is not counted against an individual's $18,000 annual expenditure cap.

Risk Demonstration Group and CHOICES Group 3 will continue to operate in a manner consistent with the approved authorities in the TennCare Demonstration.

Public Notice Process

TennCare has taken a variety of steps to ensure that members of the public are notified of these planned changes to the TennCare program. These measures include the development and maintenance of this webpage, as well as notices published in newspapers of general circulation in Tennessee communities with 50,000 or more residents.

This planned change was presented by TennCare as a budget request during Tennessee's 2022 legislative session and was subsequently approved by the Tennessee General Assembly as part of the state budget through a public legislative process.

In addition, TennCare has disseminated information about these proposed changes via its social media accounts (e.g., Facebook, Twitter).

Public Input Process

TennCare is seeking feedback on these planned changes. Members of the public are invited to offer comments regarding these changes from June 8, 2022, through July 8, 2022.

Members of the public who wish to comment on these planned changes may do so through either of the following options:

- Comments may be sent by email to public.notice.tenncare@tn.gov.
- Comments may be mailed to

  Aaron Butler, Director of Policy
  Division of TennCare
  310 Great Circle Road
  Nashville, TN 37243.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

In-Person Hearing
Location: The PEARL Room on the ground floor of the Tennessee Department of Labor and Workforce Development, 220 French Landing Drive, Nashville, TN.
Date: June 22, 2022
Time: 2:00 p.m. CT

Virtual Hearing
Location: https://tngov.webex.com/meet/JReeve
Date: June 23, 2022
Time: 10:00 a.m. CT

TennCare always appreciates input. In order to be considered prior to implementation of these changes, feedback must be received no later than July 8, 2022. Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.

TennCare Demonstration

A copy of the TennCare Demonstration is available at https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.

TennCare Page on CMS Web Site

As the federal agency with oversight authority over all Medicaid programs, CMS offers its own online resources regarding the TennCare Demonstration. Interested parties may view these materials at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.



Account #: AP105178
Company #: BUREAU OF TENNCA
Ad number #: 236853
PO #:
Note:

AFFIDAVIT • STATE OF TENNESSEE • HAMILTON COUNTY

Before me personally appeared Jim Stevens, who being duly sworn that he is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

TFP Times Free Press 06/15/22; TFP TimesFreePress.com 06/15/22

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $416.70. (Includes $10.00 Affidavit Charge).

[redacted]

Sworn to and subscribed before me this date:22nd day of June, 2022

[redacted]

My Commission Expires 02/28/2023

Sennda K. Thompson-Kilgore
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Chattanooga Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 37403

Notice of Change in the TennCare Program
CHOICES At Risk Demonstration Group (Group 3)

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes entail opening enrollment in a demonstration population known as the CHOICES At Risk Demonstration Group. This notice is provided in order to solicit public input on these planned changes.

Within the TennCare Demonstration, the CHOICES program provides managed long-term services and supports (MLTSS) for persons who are elderly or who have physical disabilities. CHOICES consists of three benefit groups. CHOICES Groups 1 and 2 consist of individuals who meet TennCare's level of care criteria for nursing facility care and either receive LTSS in a nursing facility (Group 1) or receive home- and community-based services (HCBS) in lieu of nursing facility care (Group 2). CHOICES Group 3, by contrast, consists of adults who do not meet TennCare's level of care criteria for nursing facility care but who, absent additional supports, are considered at risk of needing institutional care. These individuals receive a targeted package of HCBS intended to prevent or delay the need for nursing facility care.

Under the terms of the TennCare Demonstration, CHOICES Group 3 is open to individuals who are eligible for Medicaid as SSI recipients and to non-Medicaid-eligible individuals who qualify in the CHOICES At Risk Demonstration Group. The purpose of the CHOICES At Risk Demonstration Group is to provide a pathway for individuals who are not otherwise eligible for Medicaid to be eligible for TennCare and to receive CHOICES Group 3 HCBS. The CHOICES At Risk Demonstration has been closed to new enrollment since June 30, 2015.

In this notice, Tennessee is providing official notification that TennCare intends to re-open new enrollment in the CHOICES At Risk Demonstration Group, up to an enrollment target of 1,750 new enrollees. This change will become effective on October 1, 2022, and is expected to result in an increase in annual aggregate expenditures under the TennCare program of approximately $58.8 million.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tncare/documents2/CHOICESGroup3ComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than July 8, 2022.

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Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

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commercial appeal
PART OF THE USA TODAY NETWORK

TENNCARE BUREAU STAT
310 GREAT CIRCLE RD

NASHVILLE, TN 37243-1700

This is not an invoice

Affidavit of Publication

STATE OF WISCONSIN
County of Brown

Personally appeared before me, said Legal clerk of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennesse, who makes oath in due form of law that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached notice was published in the following issue(s) dated of The Commercial Appeal:

06/12/2022

TENNCARE BUREAU STAT 307573

[redacted]

Subscribe and sworn to before me this 12th day of June, 2022

[redacted]

Notary Public

9.19.25

My commission expires

# of Affidavits 1
Ad Number: 0005294795

VICKY FELTY
Notary Public
State of Wisconsin

Notice of Change in the TennCare Program CHOICES At Risk Demonstration Group (Group 3)

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THE JOHNSON CITY PRESS
204 W. Main Street
Johnson City, TN 37604

AFFIDAVIT OF PUBLICATION

AD# 1598933

DATES: 6-10-2022

Notice of Change in the TennCare Program
CHOICES At Risk Demonstration Group (Group 3)

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State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oath that she is a Representative of The Johnson City Press , a daily newspaper published in Johnson City, in said County and State, and that the advertisement was published in said paper for 1 insertion (s) commencing on 6-10-2022 and ending on 6-10-2022.

[redacted]
Teresa Hicks

Sworn to and Subscribed before me this 6 10 2022
Month Day Year

MARSHA MCNALLEY
STATE OF TENNESSEE
NOTARY PUBLIC
WASHINGTON COUNTY
MY COMMISSION EXPIRES NOVEMBER 30, 2024

[redacted]
Notary Public

My commission expires on 11/30/2024

This legal notice was published online at www.johnsoncitypress.com and www.publicnoticeads.com during the duration of the run dates listed. This publication fully complies with Tennessee Code Annotated 1-3-20

THE JOHNSON CITY PRESS
204 W. Main Street
Johnson City, TN 37604

AFFIDAVIT OF PUBLICATION

AD# 1598933

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Knoxville
NEWS SENTINEL
PART OF THE USA TODAY NETWORK

Attn: Jona
STATE OF TN BUREAU O F TENNCARE
310 GREAT CIRCLE ROAD

NASHVILLE, TN 37243

State of Wisconsin }

County of Brown }

Before me, the undersigned, a Notary Public in and for said county,this d: personally came said legal clerk first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of

(The Above-Referenced)

of which the annexed is a copy, was published in said paper in the issues dated:

06/14/2022

and that the statement of account herewith is correct to the best of his/he knowledge, information, and belief.

[redacted]

Legal Clerk

Subscribed and sworn to before me this June 14 2022

[redacted]

5-15-23

My commission expires

NANCY HEYRMAN
Notary Public
State of Wisconsin

Publication Cost: $211.70
Ad No: 0005296411
Customer No: 1318536

# of Affidavits 1
This is not an invoice

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AFFIDAVIT OF PUBLICATION

0005294655
Newspaper The Tennessean

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

[redacted] Sales Assistant for the above mentioned newspaper,

hereby certify that the attached advertisement appeared in said newspaper on the following dates:

06/13/22

[redacted]

Subscribed and sworn to before me this 13 day of June 2022

[redacted]
Notary Public

CHARLY NEEL
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5-7-2024

Affidavits Requested:
1

0005294655NOTICEOFCHANGEINTHETENNCAREPROG
Re: CHOICES Group 3

Classifieds

To advertise, visit:
classifieds.tennessean.com

- Classifieds Phone: **800.828.4237**
- Classifieds Email: **tnclassifieds@gannett.com**
- Public Notices/Legals Email: **publicnotice@tnmedia.com**

All classified ads are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Tennessean reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Tennessean shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

General

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Email:
handatownenterprises@gmail.com

Phone number:
931-255-0118

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jobs.tennessean.com

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ZipRecruiter | The smartest way to hire.
Get started at: jobs.usatoday.com

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Public Notices

INVITATION TO BIDDERS
FOR
TERMINAL APRON AND TAXILANE EXPANSION PHASE 2 (TATE PH.2)
PROJECT NO. **1804B**

ELECTRONIC BIDS, submitted through www.aerobidz.aero, (or SEALED NON-ELECTRONIC BIDS, if Bidder has written authorization from MNAA) for furnishing all materials, labor, tools and appurtenances for the construction for the **TATE PH.2** and other incidental items shall be received by the Metropolitan Nashville Airport Authority, not later than **2:00 P.M. (local time), July 14, 2022.** All bidders must be licensed contractors as required by the Contractor's Licensing Act of 1994, T.C.A. § 62-6-101 et seq.

A Pre-Bid Conference will be conducted at **2:00 P.M. (local time), June 21, 2022,** at 1370 Murfreesboro Pike, Building #1, Nashville, Tennessee 37217 as well as a virtual option via Microsoft Teams. If you wish to join this meeting via Microsoft Teams, please send an email to nena.bowling@flynashville.com in order to receive a calendar invite. Attendance at this meeting is not mandatory. A one-time tour of the project site will be conducted after the meeting.

Copies of the Contract Documents (ITB, Bid Schedule, Attachments, etc.) will be available on or after **June 13, 2022** and may be obtained electronically from www.aerobidz.aero, an online tendering service. The requestor shall pay the cost of the document printing.

The Small Minority Woman-Owned Business Enterprise (SMWBE) participation level established for this project is **16.48% MBE and/or WBE.** This program maintains a list of certified SMWBE's, which can be found on the Authority's website at https://flynashville.com/nashville-airport-authority/businessopportunities/business-diversity-development or certified DBEs located within the state of Tennessee, which can be found on the TNUCP Directory (TDOT) website at https://www.tdot.tn.gov/Applications/DBEDirect/Search or contacting Business Diversity Development at (615) 275-2718. Proposers are encouraged to inspect this list to assist in locating SMWBE's for the work. Other SMWBE's may be added to the list in accordance with MNAA's approved SMWBE s Program. Credit toward the SMWBE's participation will not be counted unless the SMWBE's to be used is certified by MNAA.

Further detail concerning this bid may be obtained from the MNAA web site: https://flynashville.com/opportunity_category/business.

TN-GCI0896996-01

Public Notices

0005294655

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CHOICES At Risk Demonstration Group (Group 3)

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes entail opening enrollment in a demonstration population known as the CHOICES At Risk Demonstration Group. This notice is provided in order to solicit public input on these planned changes.

Within the TennCare Demonstration, the CHOICES program provides managed long-term services and supports (MLTSS) for persons who are elderly or who have physical disabilities. CHOICES consists of three benefit groups. CHOICES Groups 1 and 2 consist of individuals who meet TennCare's level of care criteria for nursing facility care and either receive LTSS in a nursing facility (Group 1) or receive home- and community-based services (HCBS) in lieu of nursing facility care (Group 2). CHOICES Group 3, by contrast, consists of adults who do not meet TennCare's level of care criteria for nursing facility care but who, absent additional supports, are considered at risk of needing institutional care. These individuals receive a targeted package of HCBS intended to prevent or delay the need for nursing facility care.

Under the terms of the TennCare Demonstration, CHOICES Group 3 is open to individuals who are eligible for Medicaid as SSI recipients and to non-Medicaid-eligible individuals who qualify in the CHOICES At Risk Demonstration Group. The purpose of the CHOICES At Risk Demonstration Group is to provide a pathway for individuals who are not otherwise eligible for Medicaid to be eligible for TennCare and to receive CHOICES Group 3 HCBS. The CHOICES At Risk Demonstration has been closed to new enrollment since June 30, 2015.

In this notice, Tennessee is providing official notification that TennCare intends to re-open new enrollment in the CHOICES At Risk Demonstration Group, up to an enrollment target of 1,750 new enrollees. This change will become effective on October 1, 2022, and is expected to result in an increase in annual aggregate expenditures under the TennCare program of approximately $58.8 million.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/CHOICESGroup3ComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than July 8, 2022.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

- A public hearing will be held in person on June 22, 2022, at 2:00 p.m. CT in the PEARL Room on the ground floor of the Tennessee Department of Labor and Workforce Development, 220 French Landing Drive in Nashville.
- A public hearing will be held electronically on June 23, 2022, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of June 23, 2022.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

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STATE OF TENNESSEE
COUNTY OF OBION

Personally appeared before me, the undersigned Notary Public for Obion County Tennessee, David CRITCHLOW, who on oath says he is the publisher of the Union City Daily Messenger a daily newspaper of general circulation, published at Union City in said county and state, and that the hereto attached

Notice

Notice was published in said paper for 1 ~~consecutive~~ days as follows:

6/14 [redacted], 2022

Publisher [redacted]

Publisher's Fee $ 354.22

Subscribed and sworn to before me this 8th day of

July, 2022

Notary Public [redacted]

DONNA L. GIBSON
STATE OF TENNESSEE NOTARY PUBLIC
OBION COUNTY

CLASSIFIEDS

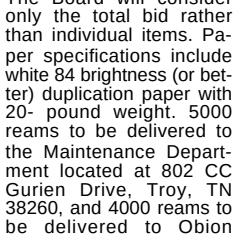
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Notice

NOTICE
The Messenger screens all classified ads prior to publishing in order to protect our readers from scams.

Our customers are important to us. If you see an ad that you are unsure of or if you respond to an ad that is a scam, please contact us.

The Messenger Classifieds Department 731-885-0744

Invitation to Bid

BID NOTICE
Paper Bid Notice 2022-2023
The Obion County Board of Education is now accepting bids on the following school supplies: White 8 _ x 11 Copy Paper 9,000 reams
The Board will consider only the total bid rather than individual items. Paper specifications include white 84 brightness (or better) duplication paper with 20- pound weight. 5000 reams to be delivered to the Maintenance Department located at 802 CC Gurien Drive, Troy, TN 38260, and 4000 reams to be delivered to Obion County Board of Education, 1700 N. Fifth St., Union City, TN. 38261.
Bids are due to the Obion County Board of Education, Wednesday, June 22, 2022, and opened on Thursday, June 23, 2022, at 1:00 p.m. Delivery must be received by July 20, 2022. We reserve the right to reject any or all bids.

Legal

BID NOTICE
Obion County Nursing and Rehab is accepting SEALED BIDS to audit the 06/30/2022 Financial Statements. The audit must be performed in accordance with generally accepted governmental auditing standards and is subject to approval by the State Comptrollers Office.
SEALED BIDS must be at the Obion County Nursing Home by June, 20 2022 by 2:00 p.m. Obion County Nursing and Rehab reserves the right to reject any and/or all bids.
EOE
6/2/2022, 6/7/2022, 6/9/2022, 6/14/2022

LEGAL
TITLE AND SUMMARY OF ORDINANCE NO 245-23 as follows: AN ORDINANCE TO APPROPRIATE AMOUNTS FROM THE HOTEL/MOTEL TAX RECEIPTS FOR FISCAL YEAR 2022-2023, TO THE OBION COUNTY INDUSTRIAL DEVELOPMENT CORPORATION, OBION COUNTY CHAMBER OF COMMERCE, AND MAIN STREET - UNION CITY, INC. AND TO DEFRAY THE CITY'S COSTS FOR COLLECTING THE TAX AND COST OF AUDITING THE TAXPAYERS.
This Ordinance was passed on first reading by the City Council of the City of Union City, Tennessee at a regular meeting held on June7, 2022.
True and correct copies of such Ordinances are on file in the office of the City Clerk of the City of Union City, Tennessee. This publication of Title and Summary is made in accordance with Section 6-21-202 of TCA (Tennessee Code Annotated).
It is the policy of the City of Union City, Tennessee not to discriminate on the basis of race, color, national origin, age, sex or disability in its hiring and employment practices, or in admission to, access to, or operation of its programs, services and activities. If special accommodations are needed in order to fully participate in this meeting, please contact City Hall at least 48 hours in advance.
Tracy Gore
City Clerk
City of Union City, Tennessee
6/14/2022

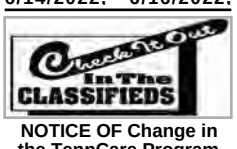
Advertise with Messenger Classifieds 731-885-0744

LEGAL
TITLE AND SUMMARY OF ORDINANCE NO 247-23 as follows: AN ORDINANCE TO SET THE TAX LEVY ON ALL TAXABLE PROPERTY WITHIN CORPORATE THE LIMITS OF THE CITY OF UNION CITY, TENNESSEE, FOR THE YEAR 2022 AND ALL FOLLOWING YEARS UNTIL CHANGED BY SUBSEQUENT ORDINANCE
This Ordinance was passed on first reading by the City Council of the City of Union City, Tennessee at a regular meeting held on June7, 2022.
True and correct copies of such Ordinances are on file in the office of the City Clerk of the City of Union City, Tennessee. This publication of Title and Summary is made in accordance with Section 6-21-202 of TCA (Tennessee Code Annotated).
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Tracy Gore
City Clerk
City of Union City, Tennessee
6/14/2022

LEGAL
TITLE AND SUMMARY OF ORDINANCE NO 246-23 as follows: An APPROPRIATIONS ORDINANCE FOR THE CITY OF UNION CITY, TENNESSEE, FOR FISCAL YEAR BEGINNING JULY 1, 2022 AND ENDING JUNE 30, 2023
This Ordinance was passed on first reading by the City Council of the City of Union City, Tennessee at a regular meeting held on June7, 2022.
True and correct copies of such Ordinances are on file in the office of the City Clerk of the City of Union City, Tennessee. This publication of Title and Summary is made in accordance with Section 6-21-202 of TCA (Tennessee Code Annotated).
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Tracy Gore
City Clerk
City of Union City, Tennessee
6/14/2022

NOTICE TO CREDITORS
35,098
ESTATE OF
Toni Lyn Yoder
(Deceased)
Notice is hereby given that on the 26th day of May, 2022, Letters Administration in respect of the estate of Toni Lyn Yoder, who died May 3rd, 2022 were issued to the undersigned by the Chancery Court of Obion, County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured, against the estate are required to file the same with the Clerk of the above named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1)
(A) Four (4) months from the date of the first publication (or posting as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or
(2) Twelve (12) months from the decedent's date of death,
This 31st day of May, 2022
Kendall Etherton
Jared Newton
Co-Administrators
Attorney for the Estate
Allison S. Whitledge
Paula Rice
Clerk and Master
6/7/2022, 6/14/2022

Notice of Sale
Contents of Storage Units
Unit A-1 belonging to:
No Owner
Unit A-2 belonging to:
Cammie Armour
Unit A-11 belonging to:
Jason Taylor
Unit A-18 belonging to:
Max Burney
Unit 25 belonging to:
Karen Lamberger
Unit A30-37 belonging to:
David or LaKeisha Hunter
Unit A-34 belonging to:
Ben Thompson
Unit A-35 belonging to:
Channin Geams
Unit-48 belonging to:
Jonathan Enochs
Unit-55 belonging to:
Christen Casey
Unit A-59 belonging to:
Carl McWherter
Unit A-60 belonging to:
Reanna McCampbell
Unit B-65 belonging to:
John Abernathy
Unit B-69 belonging to:
Jimmie Barnes
Unit B-81 belonging to:
Howard Banks
Unit B-82 belonging to:
Jimmie Barnes
Unit B-93 belonging to:
John Faulkner
Unit B-96 belonging to:
No Owner
Unit B-99 belonging to:
Betty Anderson
Unit B-102 belonging to:
Brenda Ezell
Unit B-109 belonging to:
Elizabeth Byassee
Unit B-114 belonging to:
Judy Turner
Unit B-116 belonging to:
Mamie King
Unit B-118 belonging to:
Cheryl Frame
Unit B-120 belonging to:
Diane McFall
Auction will be Saturday June 25, 2022 at 9:00 AM
Storage Plaza
415 W Main St
Union City, TN
Buildings A & B
6/14/2022, 6/16/2022,



NOTICE OF Change in the TennCare Program CHOICES At Risk Demonstration Group (Group 3)
The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of planned changes to the TennCare program. These changes entail opening enrollment in a demonstration population known as the CHOICES At Risk Demonstration Group. This notice is provided in order to solicit public input on these planned changes.
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The CHOICES At Risk Demonstration has been closed to new enrollment since June 30, 2015.
In this notice, Tennessee is providing official notification that TennCare intends to re-open new enrollment in the CHOICES At Risk Demonstration Group, up to an enrollment target of 1,750 new enrollees. This change will become effective on October 1, 2022, and is expected to result in an increase in annual aggregate expenditures under the TennCare program of approximately $58.8 million.
The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/CHOICES-Group3ComprehensiveNotice.pdf.
Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than July 8, 2022.
Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:
•A public hearing will be held in person on June 22, 2022, at 2:00 p.m. CT in the PEARL Room on the ground floor of the Tennessee Department of Labor and Workforce Development, 220 French Landing Drive in Nashville.
• A public hearing will be held electronically on June 23, 2022, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of June 23, 2022.
Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.
Copies of this notice will be available in each county office of the Tennessee Department of Health.
We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html
6/14/2022



LEGAL
TITLE AND SUMMARY OF ORDINANCE NO 244-23 as follows: AMENDMENT TO THE APPROPRIATIONS ORDINANCE FOR THE CITY OF UNION CITY, TENNESSEE, FOR FISCAL YEAR BEGINNING JULY 1, 2021 AND ENDING JUNE 30, 2022
This Ordinance was passed on first reading by the City Council of the City of Union City, Tennessee at a regular meeting held on June7, 2022.
True and correct copies of such Ordinances are on file in the office of the City Clerk of the City of Union City, Tennessee. This publication of Title and Summary is made in accordance with Section 6-21-202 of TCA (Tennessee Code Annotated).
It is the policy of the City of Union City, Tennessee not to discriminate on the basis of race, color, national origin, age, sex or disability in its hiring and employment practices, or in admission to, access to, or operation of its programs, services and activities. If special accommodations are needed in order to fully participate in this meeting, please contact City Hall at least 48 hours in advance.
Tracy Gore
City Clerk
City of Union City, Tennessee
6/14/2022

Real Estate

It is the policy of The Messenger that all advertising for the sale, rental or financing of residential real estate advertising appearing herein comply with the Federal Fair Housing Act which prohibits "any preference, limitation, discrimination because of race, color, religion, sex, handicap, familial status, or national origin, or intention to make any such preference, limitation or discrimination." In addition, the Human Rights Act prohibits such discrimination. No advertising for the sale, rental or financing of residential real estate will be refused or rejected because of race, color, religion, sex handicap, familial status or origin.
It is also the policy of this newspaper not to require different charges or terms for such advertising because of race, color, religion, sex, handicap, familial status or national origin.

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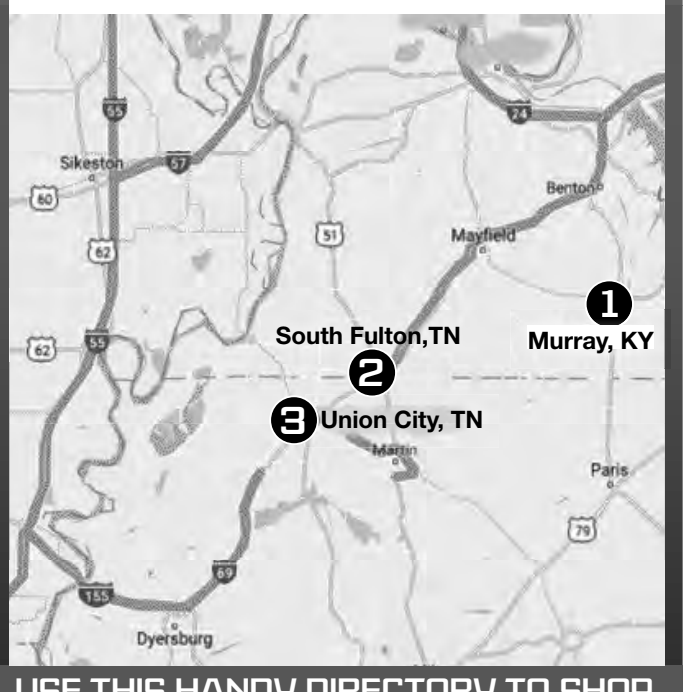
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TennCare
June 10 ·

TennCare's public comment period regarding the CHOICES At Risk Demonstration Group is now open. Effective October 1, 2022, TennCare will re-open new enrollment in the CHOICES At Risk Demonstration Group, up to an enrollment target of 1,750 new enrollees. Learn more at https://www.tn.gov/…/d…/CHOICESGroup3ComprehensiveNotice.pdf



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TennCare's public comment period regarding the CHOICES At Risk Demonstration Group is now open. Effective October 1, 2022, TennCare will re-open new enrollment in the CHOICES At Risk Demonstration Group, up to an enrollment target of 1,750 new enrollees. tn.gov/content/dam/tn...

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Attachment D

Public Comments

LEGAL AID SOCIETY
OF MIDDLE TENNESSEE AND THE CUMBERLANDS

Clarksville · Columbia · Cookeville · Gallatin · Murfreesboro · Nashville · Oak Ridge · Tullahoma

July 8, 2022

Via email to:

Aaron Butler, Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243
public.notice.tenncare@tn.gov

RE: Change to TennCare III CHOICES At Risk Demonstration Group (Group 3)

Dear Mr. Butler:

The Legal Aid Society of Middle Tennessee and the Cumberlands provides free legal assistance every year to thousands of low-income Tennesseans who live in 48 counties in Middle Tennessee and the Cumberland Plateau. Many of these Tennesseans depend on TennCare for an array of long-term services and supports. We appreciate the opportunity to submit these comments and look forward to the benefit that the proposed change would have in many of our clients' lives.

The proposed change would help clients like Ms. L. When Ms. L contacted Legal Aid, she was 85 years old. Until recently, Ms. L had been using her savings to pay to live in an assisted living facility. As she aged and her health deteriorated, Ms. L began having more frequent falls. The assisted living determined that it could no longer meet her needs, so Ms. L moved in with her daughter. Ms. L's daughter had a bedroom for Ms. L, but the doorways in the house had raised transitions, and the flooring separating the kitchen and living room was uneven. Ms. L could not safely navigate any portion of the house with her walker. Ms. L and her daughter applied for CHOICES, but Ms. L only scored a 3 on her PAE, and she made about $50 over the income limit for Group 3. Since Ms. L's daughter worked during the day, Ms. L had no choice but to unsafely navigate the house throughout the day to meet her basic needs. Ms. L was at great risk of falls which would likely lead to hospitalization and ultimately a nursing home stay. Under the proposed change, Ms. L would have access to a moderate amount of hands-on care while her daughter was at work. She also might be able to access minor home modifications to make the doorways at her daughter's house more navigable.

The proposed change would also benefit clients like Mr. H. When Mr. H contacted Legal Aid, he was a 63-year-old single parent of two minor children. After suffering health setbacks requiring surgery, Mr. H was left unable to perform many of the tasks required to sustain a household. He used a wheelchair and could not safely transfer from his wheelchair into the bed or the shower. He also needed help with things like carrying in groceries, putting away laundry, and changing bedsheets. He applied for CHOICES and scored a 4 on his PAE. He made about $100 over the

income limit for Group 3. Mr. H is currently relying on his 17-year-old child for help with his daily needs, but he is hopeful that he will be able to enroll in Group 3 as soon as the proposed changes go into effect.

While the proposed change is overall a positive one, we also have some concerns. First, we worry that the 1,750 enrollment cap may not be sufficient to meet the need. We are hopeful that this change represents a first step in expanding CHOICES Group 3 to more Tennesseans.

Second, we would take this opportunity on behalf of our clients to reiterate concerns about the underinclusive framework of the CHOICES acuity scale and its narrow eligibility requirements. We receive frequent calls from older adults and concerned family members who do not qualify for CHOICES despite needing extensive assistance in order to safely age in place at home. These elders and disabled adults may be able to lift a utensil to their mouths to eat, but they cannot access or prepare the food. They may be able to swallow a pill, but they are unable to manage their own medication schedule or open the pill bottle or container. We believe such individuals are equally "at risk" of institutionalization and should be afforded the opportunity to receive long-term services and supports in the home.

The elders and disabled people who we get to know at Legal Aid need this proposed change, and others. Nearly all of them desperately wish to be able to remain in their homes and continue to live their lives. We appreciate TennCare's commitment to home and community-based care, and we are excited to share this additional long-term care option with our clients.

Thank you for the opportunity to provide comments.

Sincerely,

Shelby Dodson
Attorney

Allison Jones
Attorney

From: [redacted]
Sent: Wednesday, June 29, 2022 6:46 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Comment for TennCare Demonstration

Hello,

My name is Brittany, and I'm currently getting TennCare through SSI.

My feedback is that the **CHOICES program needs another category**. I am physically disabled and require a significant amount of caregiving help. I am not developmentally disabled.

Whenever I talk to a CHOICES representative, they tell me **I won't qualify for category 2 or 3 because I can wipe myself after I use the bathroom**, and I can lift the spoon to feed myself. But that doesn't take into account the fact that **I can't prepare my own meals, I use a power wheelchair 24/7, I can't drive** and require many medical appointments and can't use a shuttle because the doors of public restrooms are too heavy for me to open.

I can't qualify for CHOICES 5 or 6 because I'm not developmentally disabled. When I lived in a different state before Tennessee, **I was approved for 115 hours per month to have a paid caregiver helping me**. But here, there's no program to help me. **I'm a huge burden to my family**, and they struggle to work and care for me. My mother had to take a leave from her job. **Your program needs to have a place for people like me.**

Thank you for your consideration.

[redacted]

From: [redacted]
Sent: Thursday, June 30, 2022 7:22 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Feedback on CHOICES program

Hello,

My daughter currently receives TennCare through SSI.

My feedback is that the **CHOICES program needs another category**. My daughter is physically disabled and requires a significant amount of caregiving help, but she is not developmentally disabled.

Whenever she has spoken with a CHOICES representative, they tell her **she won't qualify for category 2 or 3 because she can wipe herself after she uses the bathroom, and she can lift a spoon to feed herself.** But that doesn't take into account the fact that she needs others to prepare all of her meals, perform all of her household tasks like cleaning and laundry, and she requires a power wheelchair to move around the house. She is not able to drive, due to several physical injuries and limitations. She is unable to take a shuttle to her appointments, because most doors in public buildings do not provide a self-open option and are too heavy for her to open on her own. (This includes interior doors such as bathroom doors.) She is unable to navigate public spaces on her own and requires assistance to attend her numerous medical appointments.

My daughter **doesn't qualify for CHOICES 5 or 6 because she's not developmentally disabled.** She is disabled due to several chronic illnesses. When we lived in a different state before moving to Tennessee, she was approved for 115 hours per month to have a paid caregiver helping her. But here, there's no program to help her. She lives in my home, and it's a struggle for me to work full time and give her the care that she needs. I recently had to take an unpaid leave from my job.

Your program needs to have a category for people like my daughter, who require significant assistance due to a disability that is not a developmental disability.

Thank you for your consideration.

--
[redacted]
High School English Teacher
Connections Academy
[redacted]

From: [redacted]
Sent: Wednesday, June 29, 2022 8:41 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Comments on TennCare

Dear TennCare Representatives,

I have a granddaughter who is currently getting TennCare through SSI.

My feedback is that the CHOICES program needs another category. My granddaughter is physically disabled and requires a significant amount of caregiving help. She is not developmentally disabled.

Whenever she has spoken with a CHOICES representative, they tell her she won't qualify for category 2 or 3 because she can wipe herself after she uses the bathroom, and she can lift the spoon to feed herself. But that doesn't take into account the fact that she needs others to prepare all of her meals, she uses a power wheelchair 24/7, she can't drive and requires many medical appointments and can't use a shuttle because the doors of public restrooms are too heavy for her to open.

She can't qualify for CHOICES 5 or 6 because she's not developmentally disabled. When she lived in a different state before Tennessee, she was approved for 115 hours per month to have a paid caregiver helping her. But here, there's no program to help her. CHOICES needs to have a place for people like my granddaughter.

Thank you for your consideration.

[redacted]
Bell Buckle, TN 37020

[redacted]

From: [redacted]
Sent: Thursday, June 30, 2022 11:57 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Feedback on CHOICES program

Hello,

My sister currently receives TennCare through SSI.

My feedback is that the **CHOICES program needs another category**. My daughter is physically disabled and requires a significant amount of caregiving help, but she is not developmentally disabled.

Whenever she has spoken with a CHOICES representative, they tell her **she won't qualify for category 2 or 3 because she can wipe herself after she uses the bathroom, and she can lift a spoon to feed herself.** But that doesn't take into account the fact that she needs others to prepare all of her meals, perform all of her household tasks like cleaning and laundry, and she requires a power wheelchair to move around the house. She is not able to drive, due to several physical injuries and limitations. She is unable to take a shuttle to her appointments, because most doors in public buildings do not provide a self-open option and are too heavy for her to open on her own. (This includes interior doors such as bathroom doors.) She is unable to navigate public spaces on her own and requires assistance to attend her numerous medical appointments.

My sister **doesn't qualify for CHOICES 5 or 6 because she's not developmentally disabled.** She is disabled due to several chronic illnesses. When we lived in a different state before moving to Tennessee, she was approved for 115 hours per month to have a paid caregiver helping her. But here, there's no program to help her.

Your program needs to have a category for people like my sister, who require significant assistance due to a disability that is not a developmental disability.

Thank you for your consideration.

November 1, 2022

April Wiley
State Demonstrations Group
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-26-06
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Notice of Change to Coverage and Benefits under the TennCare Demonstration

Dear Ms. Wiley,

Pursuant to the terms and conditions of the TennCare Demonstration, Tennessee is providing official notice to CMS of our intent to make changes to coverage and benefits available under the Demonstration. These changes add allowable benefits and coverage, as permitted by the Demonstration's STCs.

Specifically, Tennessee plans to cover dental benefits for adults age 21 and older who are enrolled in TennCare. Currently, TennCare covers dental services for children under age 21, for pregnant and postpartum adults, and for certain adults receiving long-term services and supports. Beginning January 1, 2023, TennCare will cover dental services for all adults enrolled in TennCare.

We are pleased to be able to make this enhancement to the benefits available under TennCare. This change is expected to lead to improved health outcomes for persons enrolled in TennCare.

A fuller description of this change is attached to this letter. In addition, we have attached documentation of the state's compliance with the public notice requirements outlined in the Demonstration's STCs.

If you have any questions about this notice or if you need additional information, please contact Aaron Butler at 615.507.6448, or aaron.c.butler@tn.gov.

Sincerely,

[redacted]

Stephen Smith
Director, Division of TennCare

Attachments

Attachment A

Description of Changes to Coverage and Benefits

Description of Changes to Coverage and Benefits

The following provisions related to coverage and benefits under the TennCare Demonstration will become effective on January 1, 2023.

Coverage of Dental Services for Adults Age 21 and Older. Effective January 1, 2023, TennCare will cover dental services for adults age 21 and older enrolled in TennCare. Dental services for adults will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members.

Dental benefits covered for adults age 21 and older will include services from the following categories: diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics; scaling and root planing; full mouth debridement; crowns; partial dentures; complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; palliative treatment; and nitrous oxide inhalation sedation.

A list of specific procedure codes to be covered by TennCare for adults is available on TennCare's website at https://www.tn.gov/tenncare/policy-guidelines/tenncare-1115-demonstration.html. This list will be maintained on an ongoing basis as needed to reflect changes to these procedure codes.

Attachment B

Description of Public Notice and Input

Description of Public Notice and Input

Effective January 1, 2023, TennCare will cover dental services for all adults age 21 and older enrolled in the TennCare demonstration. The state has taken a variety of steps to ensure that members of the public have been notified of this planned change and have had an opportunity to provide comments and input. These measures were informed by—and comply with—the STCs of the TennCare Demonstration and 42 CFR § 431.408.

Public Notice

The state held a formal notice and comment period on this proposed change to coverage and benefits from September 23, 2022, through October 24, 2022. During this time, a comprehensive description of the planned change was made available for public review and comment on a designated page on the TennCare website. An abbreviated public notice—which included a summary description of the planned change; the locations, dates, and times of two public hearings; and a link to the full public notice on the state's website—was published in the newspapers of widest circulation in Tennessee communities with 50,000 or more residents.

The state held two public hearings to seek public comment on this planned change to TennCare benefits. One hearing took place on October 10, 2022, at 2:00 p.m., Central Time, at the TennCare building, 310 Great Circle Road, Nashville, Tennessee. The other hearing was conducted virtually and took place on October 7, 2022, at 10:00 a.m., Central Time. Members of the public also had the option to submit comments throughout the notice period by mail and/or email.

In addition, this planned change was presented as a funding request by TennCare during the 2022 session of the Tennessee General Assembly and was approved by the General Assembly as part of the state budget through a public legislative process. On September 28, 2022, TennCare published a notice of its intent to update its administrative rules to reflect coverage of dental services for adults, with a corresponding opportunity to provide public input in accordance with Tennessee's Uniform Administrative Procedures Act.

In addition, TennCare disseminated information about this proposed change, including a link to the relevant information on TennCare's website, via its social media accounts (i.e., Facebook, Twitter).

Public Comments

The state received comments from 31 individuals on this proposed change. These comments are summarized below. In addition, comments received in writing are attached in their entirety as Attachment D.

Virtually all commenters were supportive of the proposal to cover dental services for adults enrolled in TennCare. Many of these commenters emphasized the importance of dental health and/or oral health to people's overall health, quality of life, ability to work, and sense of well-being.

The state thanks these commenters for their support.

One commenter noted that Tennessee has recently begun covering dental services for pregnant and postpartum adults enrolled in TennCare and that some pregnant/postpartum adults have experienced challenges finding dental providers to furnish care. This commenter encouraged the state to ensure that an adequate number of dental providers are available to furnish care to adults enrolled in TennCare.

The state appreciates this commenter's input and is committed to ensuring that all individuals enrolled in TennCare have timely access to care. Over the preceding months, TennCare has worked with its contracted dental benefits manager (DBM) to ensure that an adequate network of providers is in place. The state will continue to work with the DBM to monitor network adequacy, availability of services, and service utilization on an ongoing basis.

One commenter suggested that TennCare should consider covering dental implants for adults.

The state thanks this commenter for their recommendation. This suggestion will be taken into consideration when planning future changes to the program. While TennCare is not proposing to cover implants at this time, the dental services covered by TennCare include other options to replace missing teeth.

One commenter suggested that in addition to dental services, TennCare should cover a more robust package of vision services for adults.

The state will take this comment into consideration when planning future changes to the TennCare program.

Attachment C

Documentation of Public Notice

Notice of Change to the TennCare III Program
Coverage of Dental Services for Adults

September 23, 2022

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of a planned change to the TennCare program. This change entails enhancements to the benefits available to adults enrolled in TennCare. TennCare is publishing this notice pursuant to 42 § CFR 431.408 and the terms and conditions of the TennCare demonstration in order to solicit public input on this planned change.

Description of Planned Program Change

Currently, TennCare covers dental services for children under age 21, for pregnant and postpartum adults, and for certain adults receiving long-term services and supports from TennCare. Dental services are not currently covered for most adults enrolled in TennCare.

Effective January 1, 2023, TennCare will cover dental services for all adults enrolled in TennCare. Dental services for adults will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members. Dental benefits covered for adults age 21 and older will include services from the following categories: diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics; scaling and root planing; full mouth debridement; crowns; partial dentures; complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; palliative treatment; and nitrous oxide inhalation sedation.

A list of specific procedure codes to be covered by TennCare for adults is available on TennCare's website at https://www.tn.gov/content/dam/tn/tenncare/documents2/DentalServicesToBeCovered.pdf This list will be maintained on an ongoing basis as needed to reflect changes to these procedure codes.

Expected Impact on Enrollment and Expenditures

This change will not result in the enrollment of additional persons in the TennCare program.

The implementation of a dental benefit for adult TennCare members is expected to result in an increase in annual aggregate expenditures of approximately $75.5 million under the TennCare program.

Evaluation Impact

TennCare does not anticipate modifying its evaluation design based on this planned change. This change is expected to contribute to key goals of the TennCare demonstration already reflected in the demonstration's evaluation design (currently under CMS review). These include enhancing coverage and benefits available under the TennCare demonstration and increasing member use of dental services under the TennCare demonstration.

Waiver and Expenditure Authorities Requested

TennCare is not requesting any new waiver or expenditure authorities under Section 1115 of the Social Security Act to implement these changes. Federal regulations at 42 CFR §§ 440.100 and 440.225 allow state Medicaid programs to provide dental services to eligible beneficiaries.

Under the terms of the TennCare III demonstration, TennCare may make changes that add allowable benefits and coverage to the program without seeking additional approval of a demonstration amendment from the Centers for Medicare & Medicaid Services (CMS).

Public Notice Process

TennCare has taken a variety of steps to ensure that members of the public are notified of this planned change to the TennCare program. These measures include the development and maintenance of this webpage, as well as notices published in newspapers of general circulation in Tennessee communities with 50,000 or more residents.

This planned change was presented by TennCare as a budget request during the 2022 legislative session and was approved by the Tennessee General Assembly as part of the state budget through a public legislative process.

In addition, TennCare has disseminated information about this proposed change via its social media accounts (e.g., Facebook, Twitter).

Public Input Process

TennCare is seeking feedback on this planned change. Members of the public are invited to offer comments regarding this change from September 23, 2022, through October 24, 2022.

Members of the public who wish to comment on this planned change may do so through either of the following options:

- Comments may be sent by email to public.notice.tenncare@tn.gov.
- Comments may be mailed to

  Aaron Butler, Director of Policy
  Division of TennCare
  310 Great Circle Road
  Nashville, TN 37243.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

Virtual Hearing
Location:
https://tngov.webex.com/meet/JReeve
Date: October 7, 2022
Time: 10:00 a.m. CT

In-Person Hearing
Location: Room 1 East A of the TennCare Building, 310 Great Circle Road, Nashville, TN.
Date: October 10, 2022
Time: 2:00 p.m. CT

TennCare always appreciates input. In order to be considered prior to implementation of this change, feedback must be received no later than October 24, 2022. Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.

TennCare Demonstration

A copy of the TennCare Demonstration is available at https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.

TennCare Page on CMS Web Site

As the federal agency with oversight authority over all Medicaid programs, CMS offers its own online resources regarding the TennCare Demonstration. Interested parties may view these materials at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.



TN Division of TennCare

TennCare's public comment period related to dental services for adult members is now open.

TennCare
46m ·

Effective January 1, 2023, TennCare will cover dental services for all adults enrolled in TennCare. TennCare is seeking public comments on this planned change. Members of the public are invited to offer comments regarding this change from September 23, 2022, through October 24, 2022. For more information visit:
https://www.tn.gov/.../AdultDentalComprehensiveNotice.pdf

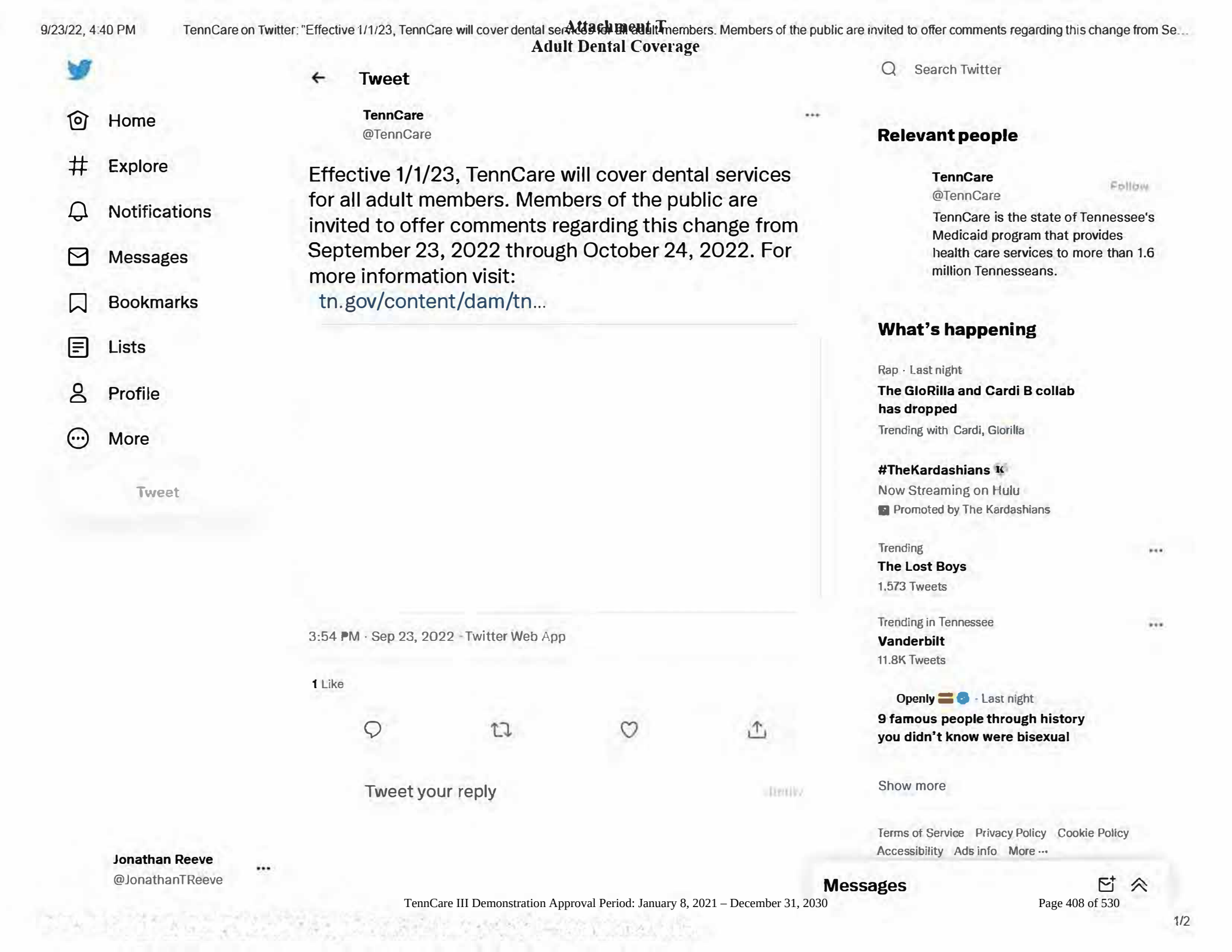
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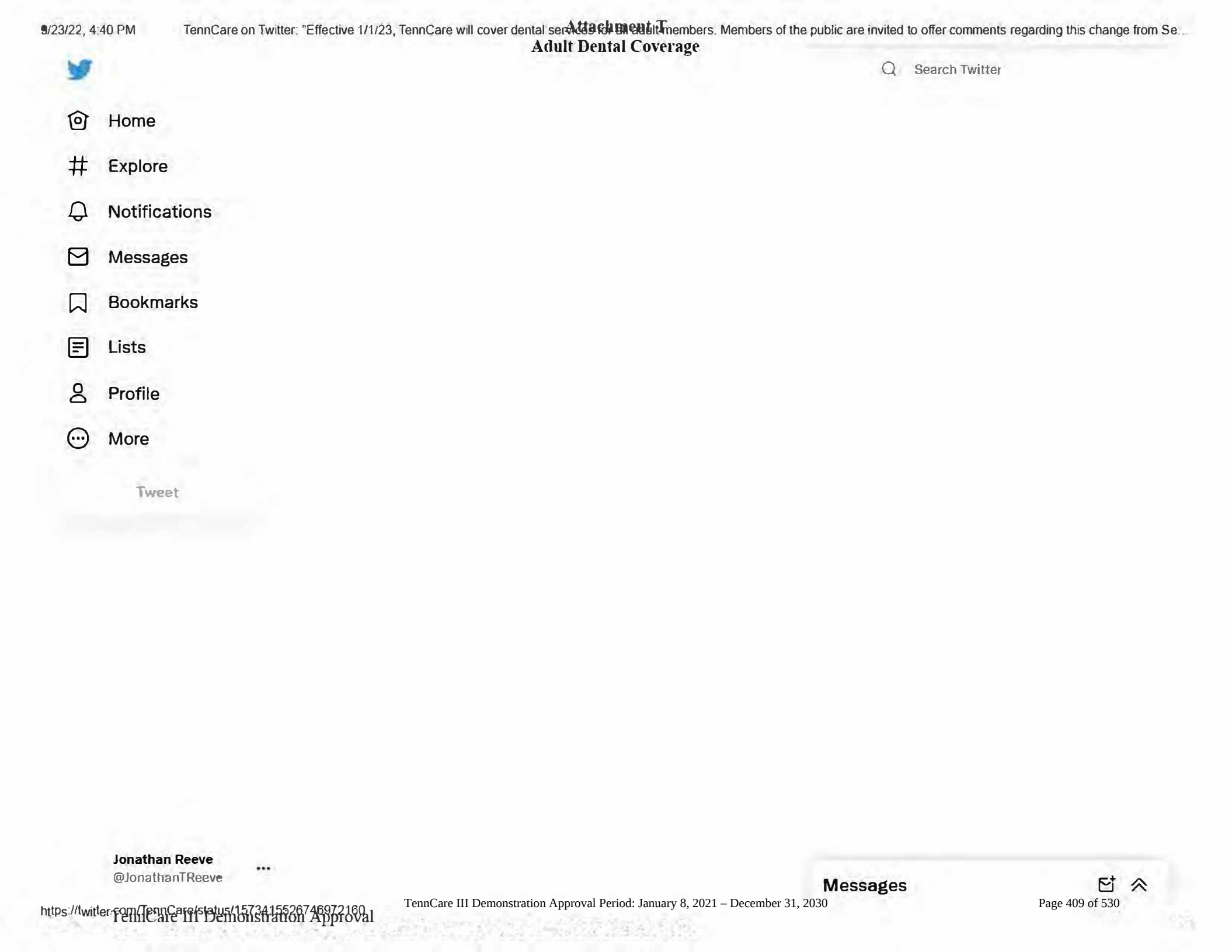
See more of TennCare on Facebook

Log In or Create new account

Attachment T
Adult Dental Coverage



Attachment T
Adult Dental Coverage





Account #: AP105178
Company #: BUREAU OF TENNCA
Ad number #: 244266
PO #:
Note:

AFFIDAVIT • STATE OF TENNESSEE • HAMILTON COUNTY

Before me personally appeared Scott Embry, who being duly sworn that he is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

TFP Times Free Press 09/27/22; TFP TimesFreePress.com 09/27/22

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $378.30. (Includes $10.00 Affidavit Charge).

[redacted]

Sworn to and subscribed before me this date:27th day of September, 2022

[redacted]

My Commission Expires 02/28/2023

Saundra K. Thompson-Rogers
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Chattanooga
Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 374

NOTICE OF CHANGE IN THE TENNCARE PROGRAM COVERAGE OF DENTAL SERVICES FOR ADULTS

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of a planned change to the TennCare program. This change entails enhancements to the benefits available to adults enrolled in TennCare. This notice is provided in order to solicit public input on this planned change.

Currently, TennCare covers dental services for children under age 21, for pregnant and postpartum adults, and for certain adults receiving long-term services and supports from TennCare. Dental services are not currently covered for most adults enrolled in TennCare.

Effective January 1, 2023, TennCare will cover dental services for all adults enrolled in TennCare. Dental services for adults will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members. Dental benefits covered for adults age 21 and older will include services from the following categories: diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics; scaling and root planing; full mouth debridement; crowns; partial dentures; complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; palliative treatment; and nitrous oxide inhalation sedation.

This change will not result in the enrollment of additional persons in the TennCare program. The coverage of dental services for adults is expected to result in an increase in annual aggregate expenditures of approximately $75.5 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/AdultDentalComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than October 24, 2022.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

- A public hearing will be held electronically on October 7, 2022, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of October 7, 2022.
- A public hearing will be held in person on October 10, 2022, at 2:00 p.m. CT in Room 1 East A of the TennCare Building, 310 Great Circle Road in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

commercial appeal
PART OF THE USA TODAY NETWORK

TENNCARE BUREAU STAT
310 GREAT CIRCLE RD

NASHVILLE, TN 37243-1700

This is not an invoice

Affidavit of Publication

STATE OF WISCONSIN

County of Brown

Personally appeared before me, said Legal clerk of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennesse, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached notice was published in the following issue(s) dated of The Commercial Appeal:

09/28/2022

TENNCARE BUREAU STAT 307573

[redacted]

Subscribe and sworn to before me this 5th day of October, 2022

[redacted]

7/27/25

My commission expires

# of Affidavits: 2
Ad Number: 0005427578

SARAH BERTELSEN
Notary Public
State of Wisconsin

Attachment T
Adult Dental Coverage

Notice of Change in the TennCare Program Coverage of Dental Services for Adults

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of a planned change to the TennCare program. This change entails enhancements to the benefits available to adults enrolled in TennCare. This notice is provided in order to solicit public input on this planned change.

Currently, TennCare covers dental services for children under age 21, for pregnant and postpartum adults, and for certain adults receiving long-term services and supports from TennCare. Dental services are not currently covered for most adults enrolled in TennCare.

Effective January 1, 2023, TennCare will cover dental services for all adults enrolled in TennCare. Dental services for adults will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members. Dental benefits covered for adults age 21 and older will include services from the following categories: diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics; scaling and root planing; full mouth debridement; crowns; partial dentures; complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; palliative treatment; and nitrous oxide inhalation sedation.

This change will not result in the enrollment of additional persons in the TennCare program. The coverage of dental services for adults is expected to result in an increase in annual aggregate expenditures of approximately $75.5 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/AdultDentalComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than October 24, 2022.

Individuals who prefer to

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

• A public hearing will be held electronically on October 7, 2022, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of October 7, 2022.

• A public hearing will be held in person on October 10, 2022, at 2:00 p.m. CT in Room 1 East A of the TennCare Building, 310 Great Circle Road in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

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Somerville, ESTATE SALE - 9/29 - 10/1
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Estate of Charles & Sarabeth Taylor

(Thu.) Sept. 29th thru (Sat.) Oct. 1st - 8 am til 4 pm

Entire House filled with Furniture, Mattresses, Antiques, Collectibles, Furs, Jewelry, Christmas Decor, Lamps, Piano, Organ, Indoor & Outdoor Tools & Equipment, Farm Tools & Equipment, Toys, Games, Clothing, Household Items, Linens, Sporting Equipment & Much Much More!

, 522 Oak St, 38068 Estate, Tennessee, Thur: 8-4, Fri: 8-4, Sat: 8-4, Dir: East on Hwy 64 to Somerville - Turn Right @ McDonalds on South Somerville St. - Go to 4 Way Stop & Turn Right - Turn Left @ Stop Sign on Oak St. - Go to End and Cross Bridge - House is on the Left @ 522 Oak St.

Garage Sales

CARAGE SALE
Designer Shoes and Clothes, Designer Handbags, Miscellaneous Housewares, Everything Must Go. 14091 Strafford Lane, Olive Branch, MS 38654 Sat: 6-2

Adopt Me Pets
all your favorites...

Domestic Pets

Purebred
AIREDALE TERRIERS
PUPS - Males & Females
8wks. $625. 731-514-0037

Beagle pups 7 wks, males $200, females $250, incls 1st shot & free bag of feed. Billy 901-626-5822

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Domestic Pets

AKC registered
Beagles $300.00 AKC/NKC registered beagle puppies. Championship hunting/bench bloodlines. 5 males/1female available. (662)664-2305

DOG, BOSTON TERRIER $$1500, FEMALE, , 6 WEEKS , 3 BLACK/WHITE 1 BRINDLE, CKC REGISTERED JARVIS 901-461-3189 (901)461-3189

German Shepherd Puppies 6 wks, AKC. Sable, Black/Tan. Shots, wormed. $700. 870-761-3709

SHORKIES & HAVACHONS - small hypoallerg breeds - $699 w/vet ck, CKC reg, cur vacc, 10-dy guarantee. 1hr east of Memphis: www.preciouspuppiespuppykennel.com. Member BBB, ensuring quality pets at affordable prices! Call/txt 662.284.6991

ATTENTION
Toy Poodle Pups, Reg. ACA, 8 Wks, F, Red, Apricot, S/w, 870 577 7158

Westie Pups - Reg. S/W. $1,200 Males. Parents on site Ph/text/Pics: 870-408-1607

Livestock - Poultry

Registered Quarter Horse Bay Gelding, well brake, 8 yrs old, $650. 870-932-3463

Assorted Stuff
all kinds of things...

Appliances

Stainless Steel full sheet pan size reach in refrigerator & also reach in freezer both units together for $1,250. Call 901-289-8471

Cemetery Lots

Memphis Memorial rest in peace 6 plots avail, will divide. Randy 860-526-2050



Memphis Mem. Pk Cemetery. 3 plots, sec E, spaces 1, 2, 3. $4,995. 901-277-5051

2 Plots at Forest-Hill East. Garden of Prayer area, $5,200 for both. 417-414-8911

Furniture Household



74" Rosewood oriental bench with Mother of Pearl inlay, from the 1950's, $2,500. 901-487-6227

Hunt-Fish-Camp

HUNTING LEASE
126.3 Acres - 4-acre Lake in Chester Country across from Chickasaw State Park, 88 miles from Memphis. Call Bernie J. Brown, Jr., 901-685-9222.

Miscellaneous

Two Used tires, Good Condition, MS 235 55 R18 Asking $40 Call 901 754 3769

Novena

Thank you Saint Expedite For answering my prayers! -BC

Wanted to Buy

LOOK!
INSTANT CASH PAID for baseball cards, sports memorabilia, autographs, game used sports items, coins, gold, silver, watches, diamonds, old toys, trains, comic books, old photos, military, presidential, huge collections, lots of others. Scott, 513-295-5634 Instant Cash Paid goodasgold#roadrunner.com

Real Estate Rentals
great places to live...

Apartments

FREE- 1/2 Mo. Rent & Cable, Gated Access, Quiet, Renovated, Unfurn. $550 - $730. Furn. $600 - $780 901-472-4200

Free Rent
901-459-5726

LOOK
FULLY FURNISHED FREE Utilities & FREE Cable. Laundry onsite. Stay Where You're Appreciated! NO Credit Checks & LONG-TERM Leases. Call 901-250-1480

MOVE IN TODAY!
No long-term lease and Bad Credit OK. FULL Kitchenettes. FREE Utilities, cable, WIFI. Laundry onsite. PET FRIENDLY. Flexible payment options. Earn FREE STAYS, Stay Where You're Appreciated! Call- 901-472-8280.

Condo/Townhome Rent

This Out!
Hickory Hill - Single level, 3BR, 2 full BA. $1200/mo + $1200 security deposit. Call: 901-230-6957

Homes For Rent

Hickory Hill 4193 Cedartree 2BR Townhouse, 2 BA., C/AC & HT $995mo. $800 deposit 901-212-7431

PROPERTY LOCATED IN THE ZIP CODE 38106
2BD 1BTH $1,200.00 A MONTH
NEWLY RENOVATED

PROPERTY LOCATED IN ZIP CODE 38019
4BD 2.5BTH $3,500.00 A MONTH
NEWLY RENOVATED

PROPERTY LOCATED IN ZIP CODE 38127
2BD 2BTH $1,325.00 A MONTH
NEWLY RENOVATED

PROPERTY LOCATED IN ZIP CODE 38128
4BD 2BTH $2,100 A MONTH
NEWLY RENOVATED!

PROPERTY LOCATED IN ZIP CODE 72301
3BD 1BTH $1,300.00 A MONTH
NEWLY RENOVATED

Shelby Dr 4736 Queenlace Crt 2bedroom, both half $700 deposit 901-212-7431

Rooms For Rent

Furnished Rooms/ Air/ Free Wifi/ Utils incl/ W/D/ Alarm system/ Drug free/ Manager on site/ $140 a week & up. Call 901-501-1281

Memphis - Nice rooms, central heat & air, w/d, phone & cable. $150/wk, $50/dep. 901-864-0655 or 901-775-7712

Midtown: Furnished, Very clean room. Incld's utilities Senior Owned. 901-412-0638

Rooms for Rent $500-$800, Cable, Wifi, Washer. North Memphis (901)295-2284

Real Estate Homes
starting fresh...

Homes For Sale - In State

EQUAL HOUSING OPPORTUNITY
Equal Housing Opportunity
All real estate advertising in this newspaper is subject to the Federal Fair Housing Act of 1968 which makes it illegal to advertise any preference, limitation or discrimination based on race, color, religion, sex, national origin, handicap or familial status or an intention to make any such preference, limitation or discrimination.

This newspaper will not knowingly accept any advertising for real estate which is in violation of the law. Our readers are hereby informed that all dwellings advertised in this newspaper are available on an equal opportunity basis.

FINDING WORK SHOULDN'T BE WORK.
jobs. ZipRecruiter
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Public Notices

NOTICE OF PUBLIC REVIEW

The Tennessee Department of Transportation (TDOT) announces the beginning of a 30-day review and comment period on its 2023-2026 State Transportation Improvement Program (STIP). The STIP establishes projects for major construction and Public Transit over the four-year period, which will utilize available and projected Federal funds. The review period is to provide citizens, affected public agencies, employees of transportation agencies, various stakeholder groups and other interested parties a reasonable opportunity to comment on the STIP. The STIP can be accessed by going to TDOT's home page www.tn.gov/tdot or at https://www.tn.gov/content/dam/tn/tdot/programdevelopment/2023-2026-stip-draft/Tennessee%20STIP%202023-2026%20Draft-R.pdf

Written comments may be submitted at any time during the comment period to: Mr. Brian Hurst, Transportation Manager II, Suite 600, James K. Polk Bldg, 505 Deaderick Street, Nashville, TN 37243-0341, (615) 253-1110, www.TDOT.Comments@tn.gov In addition, appropriate TDOT staff will be available at the Regional Offices to answer questions and accept comments on the following dates:

Region 1: Wednesday, October 19, 2022, 4:00 6:00 p.m. EDT
7345 Region Lane, Knoxville, TN 37914, (865) 594-2400

Region 2: Thursday, October 20, 2022, 4:00 6:00 p.m. EDT
7512 Volkswagen Drive, Chattanooga, TN 37421, (423) 892-3430

Region 3: Monday, October 24, 2022, 4:00 6:00 p.m. CDT
6601 Centennial Blvd, Building R, Nashville, TN 37243, (615) 350-4300

Region 4: Monday, October 17, 2022, 4:00 6:00 p.m. CDT
300 Benchmark Place, Jackson, TN 38301, (731) 935-0100

TDOT will respond to all comments. The Tennessee Department of Transportation is an Equal Opportunity Employer and does not discriminate on the basis of race, age, sex, religion, color, disability, or national origin.

Automotive Wheels
best deal for you...

Autos Wanted

Auto auction at 1780 Getwell Rd Memphis TN 38111, On 09/24/22 at 9:00 am 2018 Chevrolet Malibu VIN#1G1ZB5ST4JF252105, 2011 Kia Sorento VIN#5XYKT4A29BG128161, 2018 Toyota Corolla VIN#2T1BURHEXJC072235, to cover storage fee., (901)292-6737

WANTED
I BUY ANTIQUE CARS, CLASSICS. Call or send pics for highest cash offer! 901-219-9569

Cars

1998 Jaguar Vanden Plas, Approx 55K actual miles, needs paint, interior leather good condition, runs good, 8cyl, fare condition. $8500 Great car to restore Call 901-340-4821

Trucks

2001 Ford F150 , Custom 4 door, super cab, XLT: 118K Miles, Tow bar, drive shaft disconnect, air break kit, Have original drive shaft, Towed behind Allegro Bus. in Southaven $10,950 Call 901-482-1154

Vans

2004 Chevy Astro work van, runs good, $3,500. Call 901-289-8471

Vehicles Recreation
RVs, motorcycles, etc.

Recreational Vehicle

ATTENTION
I BUY CAMPERS, TRAILERS, & MOTOR HOMES- ALL TYPES. ready to go or need work. For FAST CASH Call Lawrence at 931-242-3135

Your Source Public Notices
for the latest...

Legal Notices

Notice of Change in the TennCare Program
Coverage of Dental Services for Adults

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of a planned change to the TennCare program. This change entails enhancements to the benefits available to adults enrolled in TennCare. This notice is provided in order to salicit public input on this planned change.

Currently, TennCare covers dental services for children under age 21, for pregnant and postpartum adults, and for certain adults receiving long-term services and supports from TennCare. Dental services are not currently covered for most adults enrolled in TennCare.

Effective January 1, 2023, TennCare will cover dental services for all adults enrolled in TennCare. Dental services for adults will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members. Dental benefits covered for adults age 21 and older will include services from the following categories: diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics; scaling and root planing; full mouth debridement; crowns; partial dentures; complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; palliative treatment; and nitrous oxide inhalation sedation.

This change will not result in the enrollment of additional persons in the TennCare program. The coverage of dental services for adults is expected to result in an increase in annual aggregate expenditures of approximately $75.5 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/AdultDentalComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than October 24, 2022.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

- A public hearing will be held electronically on October 7, 2022, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of October 7, 2022.
- A public hearing will be held in person on October 10, 2022, at 2:00 p.m. CT in Room 1 East A of the TennCare Building, 310 Great Circle Road in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

Public Notices

Seeking Title for a 2015 Honda Forza Scooter, Red
VIN: LHNF04075100149
Anyone with an interest in this vehicle contact Austin Barr, 7931 Burntwood Cove Germantown TN 38138, within 10 business days of this notice by certified mail, return receipt requested.

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The Smartest Way To Hire
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jobs.usatoday.com





Business & Service Directory

to advertise, email: **ServiceDirectory@commercialappeal.com** or call: **901.529.2211**

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GREAT DEAL
CONCRETE WORK
43 yrs. exp. - All types - specializing in patios, drives sidewalk, slabs. Free Est. Work Gtd. Odis 901-489-2427

Firewood and Fuel

CHIMNEYS CLEANED & REPAIRED
Chimney Covered Installed Gas Logs & Gas Lines Sold, Serviced & Installed. Gas Log Experts (901)331-3521

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LOOK!
JACK POPE - Int/ext paint, Carpentry, Concrete. Lic ./Bonded. 901-486-1146

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SUPERIOR LAWN CARE
• Mowing • Trimming,
• Hedging • Mulching,
• Leaf Cleanups
• Flower Bed Work
• Landscape Design
Call Today For Your Free Estimates
901-572-0473

Miscellaneous Biz and Services

Experienced CARE GIVER 20+ yrs. exp. Will run errands; Dr Appts, Meal Preparation; Light House Keeping; Any Shift; Avail Now! Call 901.650.7759

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Affordable Painting
Interior Exterior. Popcorn/ Wallpaper Removed, Exterior Pressure Wash, Rotten Wood replaced Free Est! 25yrs. Exp.-Insured
Robert Currie * 901-237-1200

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FRED'S PLUMBING
Drain cleaning, faucets, commodes, water heaters, repair/replace, install sinks, disposals. 901-258-9191

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GOT AN UNSATIFIED JUDGMENT?
We Specialize in the enforcement of judgments. Call before they expire 901-441-7775

PROFESSIONAL SECURITY GUARD
Private, Weddings & Residential
Including Sr. Citizens.
Call: 901-606-2679

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RE-ROOF AND REPAIRS
By Certified ROOFERS
Flats, shingles, chimneys, copper flashings, slate, tile, valleys, vents, carpentry & home repairs, gutters cleaned & installed Free estimates Lic/bonded A+BBB mbr. 49 years experience.
MIKE NIX
901-682-4499; 359-4499

Homes

Roofing - Siding

CALL NOW
ROOFING & REPAIRS
20 yrs. exp. All Roofing & Repairs! Gutter install. Flat roof, tear off. Lic/Ins Bonded. Free Roof Inspections 901-406-1720
BBB Member Home Restoration Company

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jobs.commercialappeal.com

AFFIDAVIT OF PUBLICATION

0005427569
Newspaper Jackson Sun

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

[redacted] Sales Assistant for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

09/28/22

[redacted]

Subscribed and sworn to before me this 28 day of Sept 2022

[redacted]
Notary Public

Affidavits Requested:

2

0005427569NOTICEOFCHANGEINTHETENNCAREPROG
Re: Dental Service

Classifieds

To advertise, visit:
classifieds.jacksonsun.com

- Classifieds Phone: **800.366.4189**
- Classifieds Email: **tnclassifieds@gannett.com**
- Public Notices/Legals Email: **publicnotice@tnmedia.com**

All classified ads are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Jackson Sun reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Jackson Sun shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

Adopt Me Pets
all your favorites...

Domestic Pets

Maine coon kittens available. Both male and female, up to date on shots, trained and home raised with great temperament. Call/text (205) 851-4047 for more inquiries or email : colocoons@gmail.com

Pit bull, Female, , Friendly FOUND - Lost dog in Westover/Boone Lane area (731)616-3541

Toy Australian Shepherd, 2 Males/ 1 Female, 11 weeks, Purebred. 2 BKM 1 BKF. Champion bloodlines, pedigree, registered, UTD shots & wormer, genetic testing cleared through parentage, tail/dews removed, Bred in our home. Ready now, www.bodiconminiaussies.com $2700 (518)495-5272 juney2kmom@aol.com

On The Farm
all things farming...

Farm Services

U PICK Fresh mustard and turnip greens $15/ bushel (731) 694-0440 (Mike Weir)

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jobs. ZipRecruiter
Get started by visiting
jobs.jacksonsun.com

Great Buys Yard Sale
neighborly deals...

Madison North

1 DAY ONLY
ANNUAL FOX RIDGE YARD SALE PINE WOOD DRIVE, SATURDAY OCTOBER 1ST, 7A.M. TO 1PM, Dir: MILE EAST OF US HWY 412 & 70 INTERSECTION CLOTHES, FURNITURE, APPLIANCES, ELECTRONICS, TOYS.

Real Estate Homes
starting fresh...

Commercial

EQUAL HOUSING OPPORTUNITY
Equal Housing Opportunity
All real estate advertising in this newspaper is subject to the Federal Fair Housing Act of 1968 as amended which makes it illegal to advertise "any preferences, limitation, or discrimination based on race, color, religion, sex, handicap, familial status or nation origin, or on intention to make any such preference, limitation or discrimination.
"This newspaper will not knowingly accept any advertisement for real estate which is in violation of the law. Our readers are hereby informed that all dwellings advertised in this newspaper are available on an equal opportunity basis. To complain of discrimination, call HUD Toll-free at 1-800-669-9777. For hearing impaired call 1-800-927-9275.

NEED TO SELL YOUR HOUSE?



TO BOOK YOUR REAL ESTATE CLASSIFIED AD
Contact your local Real Estate sales representative today

Real Estate Services

EQUAL HOUSING OPPORTUNITY
Equal Housing Opportunity
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Your Source Public Notices
for the latest...

Public Notices

0005427503
The City of Jackson will receive sealed bids for Resurfacing 4 Tennis Courts at the Tennis Complex until 10:30 a.m., Tuesday, October 25, 2022. Bid list invitations must be obtained from zpolk@jacksontn.gov . Bids must be mailed or delivered to City Hall, 115 E. Main St., Suite 202, Jackson, TN 38301 Attn: Purchasing. The City reserves the right to waive informalities and to reject any and all bids/proposals. The City of Jackson is an Equal Opportunity Title VI employer.
Zach Polk
Director of Purchasing
dept. 41610

Careers Jobs
new beginnings...

General



Medical specialty office
is currently looking to hire an
LPN
Monday-Friday
8:00am – 4:30pm
Please call
731-984-8390
to learn more or email resumes to
carla@advancedkidney.com
TN-GCI0942721-01

Continued from last column

0005428280
The City of Jackson will receive sealed bids for Southside Community Center Floors until 10:30 a.m., Tuesday, October 25, 2022. Bid list invitations must be obtained from zpolk@jacksontn.gov . Bids must be mailed or delivered to City Hall, 115 E. Main St., Suite 202, Jackson, TN 38301 Attn: Purchasing. The City reserves the right to waive informalities and to reject any and all bids/proposals. The City of Jackson is an Equal Opportunity Title VI employer.
Zach Polk
Director of Purchasing
dept. 41610



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Careers Jobs
new beginnings...

General

Medical specialty office
is currently looking to hire an
LPN
Monday-Friday
8:00am – 4:30pm
Please call
731-984-8390
to learn more or email resumes to
carla@advancedkidney.com

Public Notices

Public Notices

0005427569
Notice of Change in the TennCare Program Coverage of Dental Services for Adults

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of a planned change to the TennCare program. This change entails enhancements to the benefits available to adults enrolled in TennCare. This notice is provided in order to solicit public input on this planned change.

Currently, TennCare covers dental services for children under age 21, for pregnant and postpartum adults, and for certain adults receiving long-term services and supports from TennCare. Dental services are not currently covered for most adults enrolled in TennCare.

Effective January 1, 2023, TennCare will cover dental services for all adults enrolled in TennCare. Dental services for adults will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members. Dental benefits covered for adults age 21 and older will include services from the following categories: diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics; scaling and root planing; full mouth debridement; crowns; partial dentures; complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; palliative treatment; and nitrous oxide inhalation sedation.

This change will not result in the enrollment of additional persons in the TennCare program. The coverage of dental services for adults is expected to result in an increase in annual aggregate expenditures of approximately $75.5 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at **https://www.tn.gov/content/dam/tn/tenncare/documents2/AdultDentalComprehensiveNotice.pdf** .

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to **public.notice.tenncare@tn.gov**. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than October 24, 2022.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

- A public hearing will be held electronically on October 7, 2022, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at **https://tngov.webex.com/meet/JReeve** on the morning of October 7, 2022.
- A public hearing will be held in person on October 10, 2022, at 2:00 p.m. CT in Room 1 East A of the TennCare Building, 310 Great Circle Road in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at **HCFA.fairtreatment@tn.gov** prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. **https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html**

Business & Service Directory

to advertise, email: **ServiceDirectory@jacksonsun.com** or call: **800.366.4189**

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Price Varies.
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Bzybzzllc@gmail.com

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Education Programs & Sports. Jelani Tolbert Tutors 1st through 12th grade in English, Math, Reading, Spelling, Science, & Social Studies. Spanish & Art taught by Cidalia. Brandi Girley Music & Theory Teacher
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Bengamon- Jonathan Mendez camping in Soccer.
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2745 Ashport Rd
Jackson, TN 38305

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Loader, excavator, dozer clearing. Driveways. Clean ditches. Pond banks. Culverts. Patios. Leveling. Stumps.
Raymond Phillips O/O
Free Estimates
731-660-6940 or 731-217-5733

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Home Improvement

DOORS & MORE- Quality Garage DoorInstallations, Sales & Service. Beautiful Handrails & Mailboxes. Call 731-249-5133 or 731-967-4161 doorsandmore.pro

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MOBILE HOME PARTS, INC.
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Furnace Parts, Motors
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We hove everything to make your home new again.
We also install.
W/financing 12 mo. same as cash
Financing Available
Mon-Fri, 8am - 5pm

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PINSON HOME REPAIR
Serving ALL WEST TENNESSEE
10% DISCOUNT FOR SENIOR CITIZENS.
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Insurance claims welcome.
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General Contractor.
BILLY C RAMEY
Call 731-431-4706

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TOP PRICES FOR YOUR TIMBER
Hardwood and/or Pine.
Quality work.
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Lawn - Garden Care

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20 & 40 ft. containers
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Lawn - Garden Care

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Place your classified ad today.

THE JOHNSON CITY PRESS
204 W. Main Street
Johnson City, TN 37604

AFFIDAVIT OF PUBLICATION

AD# 1610106

DATES: 9-27-2022

Notice of Change in the TennCare Program Coverage of Dental Services for Adults

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of a planned change to the TennCare program. This change entails enhancements to the benefits available to adults enrolled in TennCare. This notice is provided in order to solicit public input on this planned change.

Currently, TennCare covers dental services for children under age 21, for pregnant and postpartum adults, and for certain adults receiving long-term services and supports from TennCare. Dental services are not cur-rently covered for most adults enrolled in TennCare.

State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oath that she is a Representative of The Johnson City Press , a daily newspaper published in Johnson City, in said County and State, and that the advertisement was published in said paper for 1 insertion (s) commencing on 9-27-2022 and ending on 9-27-2022.

[redacted]

Sworn to and Subscribed before me this 9 27 2022
Month Day Year

MARSHA MCNALLEY
STATE OF TENNESSEE NOTARY PUBLIC
WASHINGTON COUNTY
MY COMMISSION EXPIRES NOVEMBER 30, 2024

[redacted]
Notary Public

My commission expires on 11/30/2024

This legal notice was published online at www.johnsoncitypress.com and www.publicnoticeads.com during the duration of the run dates listed. This publication fully complies with Tennessee Code Annotated 1-3-20

THE JOHNSON CITY PRESS
204 W. Main Street
Johnson City, TN 37604

AFFIDAVIT OF PUBLICATION

AD# 1610606

DATES: 9-27-2022

State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oa ;s , a

daily newspaper publishe

advertisement was publis n

9-27-2022

Sworn to and Subscribed

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www.publicnoticeads.com tion fully
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This change will not result in the enrollment of additional persons in the TennCare program. The coverage of dental services for adults is expected to result in an increase in annual aggregate expenditures of approximately $75.5 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/AdultDentalComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than October 24, 2022.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

- A public hearing will be held electronically on October 7, 2022, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of October 7, 2022.
- A public hearing will be held in person on October 10, 2022, at 2:00 p.m. CT in Room 1 East A of the TennCare Building, 310 Great Circle Road in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

Knoxville
NEWS SENTINEL
PART OF THE USA TODAY NETWORK

Attn: Jona
STATE OF TN BUREAU O F TENNCARE
310 GREAT CIRCLE ROAD

NASHVILLE, TN 37243

State of Wisconsin)

County of Brown)

Before me, the undersigned, a Notary Public in and for said county,this day personally came said legal clerk first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of

(The Above-Referenced)

of which the annexed is a copy, was published in said paper in the issues dated:

09/28/2022

and that the statement of account herewith is correct to the best of his/her knowledge, information, and belief

[redacted]

Subscribed and sworn to before me this October 5 2022

[redacted]

7/27/25
My commission expires

SARAH BERTELSEN
Notary Public
State of Wisconsin

Publication Cost: $285.12
Ad No: 0005428268
Customer No: 1318536

# of Affidavits: 1
This is not an invoice

Attachment T
Adult Dental Coverage

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Coverage of Dental Services for Adults

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Adult Dental Coverage

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AFFIDAVIT OF PUBLICATION

0005427569
Newspaper Leaf Chronicle

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

[redacted] Sales Assistant for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

09/28/22

[redacted]

Subscribed and sworn to before me this 28 day of Sept 2022

[redacted]

CHARLY NEEL
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5-1-2024

Affidavits Requested:
1

0005427569NOTICEOFCHANGEINTHETENNCAREPROG
Re: Dental Service

Classifieds

To advertise, visit:
classifieds.theleafchronicle.com

- Classifieds Phone: **931.552.1234**
- Classifieds Email: **tnclassifieds@gannett.com**
- Public Notices/Legals Email: **publicnotice@tnmedia.com**

All classified ads are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Leaf Chronicle reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Leaf Chronicle shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

Your Source Public Notices for the latest... Public Notices

0005427569

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Your Source Public Notices for the latest... Public Notices

0005407444

STATE OF SOUTH CAROLINA) IN THE PROBATE COURT
COUNTY OF GREENVILLE) C.A. #2022ES2301547

Marty L. Roberts,
Petitioner,
v.
Allen Roberts, Robin Roberts, Amber Roberts, Mike Roberts, III, Justice Roberts and Ashley Roberts Nelson,
Respondents,
In Re:
Mike M. Roberts, Sr., Deceased.

SUMMONS

TO THE RESPONDENTS ABOVE NAMED:
You are hereby summoned and required to answer the Petition in this action, of which a copy is herewith served upon you, and to serve a copy of your answer to the said Petition on the subscriber at his offices, 601 E. McBee Avenue, Suite 104, Greenville, S.C., within thirty (30) days after the service hereof, exclusive of the day of such service; and if you fail to answer the Petition within the time aforesaid, the Petitioner in this action will apply to the Court for a default judgment for the relief demanded in the Petition.
A hearing in this matter is scheduled for November 7, 2022, commencing at 2:00 pm in the Probate Court for Greenville County, South Carolina.

ASHMORE LEAPHART & RABON, LLC
By: Ben G. Leaphart
Attorneys for Petitioner
P. O. Box 10766
601 E. McBee Avenue, Suite 200
Greenville, SC 29603
August 3, 2022. (864) 271-2594

Real Estate Homes starting fresh... Commercial

EQUAL HOUSING OPPORTUNITY
Equal Housing Opportunity
All real estate advertising in this newspaper is subject to the Federal Fair Housing Act of 1968 as amended which makes it illegal to advertise "any preferences, limitation, or discrimination based on race, color, religion, sex, handicap, familial status or nation origin, or an intention to make any such preference, limitation or discrimination.
"This newspaper will not knowingly accept any advertisement for real estate which is in violation of the law. Our readers are hereby informed that all dwellings advertised in this newspaper area available on an equal opportunity basis. To complain of discrimination, call HUD Toll-free at 1-800-669-9777. For hearing impaired call 1-800-927-9275.

Homes



Public Notices

NOTICE FOR PUBLICATION IN NEWSPAPER OF LOCAL DISTRIBUTION
In accordance with TCA Section 7-82-401, the following financial information was taken from the audited financial statements of East Montgomery Utility District as of and for the year ended June 30, 2022. A copy of the financial report is available for public inspection during regular business hours at the District's Office.

STATEMENT OF NET POSITION

Current assets	$ 8,534,773
Restricted assets	414,819
Capital assets, net of $9,866,035 of accumulated depreciation	10,304,455
Deferred outflows of resources	303,597
Total assets and deferred outflows of resources	$ 19,557,644
Current liabilities	$ 474,045
Long-term liabilities	1,706,967
Total liabilities	2,181,012
Deferred inflows of resources	134,614
Total net position	17,242,018
Total liabilities, deferred inflows of resources and net position	$ 19,557,644

STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

Operating revenues	$ 2,892,201
Operating expenses (excluding depreciation)	(1,933,115)
Depreciation	(529,999)
Non-operating revenues	560,956
Change in net position	$ 990,043

Utility Rates in Effect As Of January 1, 2022

Minimum Rate - First 1,000 Gallons or Less	$16.50
All Over 1,000 Gallons -	$ 6.00 per 1,000 Gallons

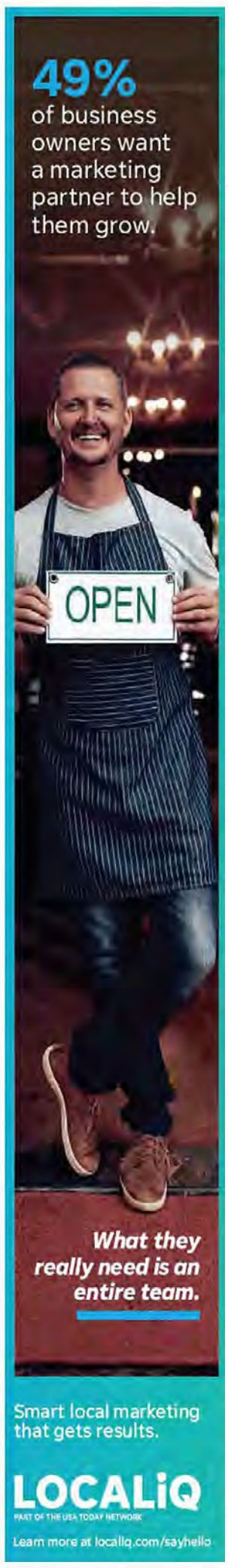
These rates were derived based on the cost to serve customers and to run the utility.

Travel Cost/Expense for June 30, 2022	
Travel Cost/Expense for June 30, 2022	
Board of Commissioners	$1,004.14
Management	$1,127.46
Employees	$ 0.00

East Montgomery Utility District's regular board meeting scheduled for the second Monday of each month will change from October 10, 2022 at 1:00 P.M. to Tuesday, October 11, 2022 at 1:00 P.M.

East Montgomery Utility District's regular board meetings are scheduled for the second Monday of each month at 1:00 P.M.

"This institution is an equal opportunity provider and employer"



TO BOOK YOUR
REAL ESTATE
CLASSIFIED AD



Contact your local real estate sales representative today

Business & Service Directory

to advertise, email: **ServiceDirectory@theleafchronicle.com** or call: **931.552.1234**

Professional Service all your needs... Business Service

A REPAIRS UNLIMITED
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- Drywall
- Roofing
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- Windows
- Plumbing & Electric.

Call 931-801-7859

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MOM'S CLEANING SERVICE
Residential/Commercial, Weekly, Bi-Weekly, Monthly & 1 time cleans.
No One Cleans Like Mom!
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Call 931-627-7544

Wanted: A Car that lets you decide where to park. Find what you want in The Leaf-Chronicle Classifieds.

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ALL WE DO IS HOME REPAIR & HANDYMAN SERVICES:
Decks Fencing
Complete Remodeling
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KUCINSKI DRY WALL
We're the Business that Does Small Jobs & Repairs!!
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- Painting • Installation
- Taping • Finishing
- Radiant Heat Removal

Call Steve · 931-645-8027

SELL IT BUY IT FIND IT

cars, garage sales, tickets, antiques, motorcycles, computers, boats, sports, equipment, pets, instruments, jewelry, furniture, auctions, collectibles, jobs, appliances, yard sales, tablets, cameras

Place your classified ad today.



0005427569

Affidavit of Publication

NEWSPAPER: Tennessean

BUREAU OF TENNCARE
310 GREAT CIRCLE RD.
NASHVILLE, TN 37243

State of Tennessee

ADVERTISER: BUREAU OF TENNCARE
ACCOUNT # 00381001

TEAR SHEETS
ATTACHED

RE: NOTICE OF CHANGE IN THE TENNCARE PROGRAM COVERAGE OF DENTAL SERVICES FOR ADULTS

I, [redacted] Advertising Assistant for the above mentioned newspaper, hereby certify that the attached advertisement

Appeared in said newspaper on the following dates: 09-28-2022

[redacted]

Subscribed and sworn to me this 28 day of September, 2022

[redacted]
NOTARY PUBLIC

CHARLY NEEL
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 5-7-2024

Classifieds

To advertise, visit:
classifieds.tennessean.com
Classifieds Phone: 800.828.4237
Classifieds Email: tnclassifieds@gannett.com
Public Notices/Legals Email: publicnotice@tnmedia.com

All classified ads are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Tennessean reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Tennessean shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

Your Source
Public Notices
for the latest...

Public Notices

0005429049

NOTICE OF SALE
500 Murfreesboro Road
Franklin, TN 37064

LEGAL NOTICE: Pursuant to 28 U.S.C. § 2001, Burton W. Wiand, as the Court-appointed Receiver in SECURITIES AND EXCHANGE COMMISSION V. BRIAN DAVISON, et al., CASE NO. 8:20-CV-325-T-35AEP (M.D. Fla.), will conduct a private sale of the property located at 500 Murfreesboro Road, Franklin, TN 37064 to David Douglas and/or a related entity for $505,000. The sale is subject to approval by the U.S. District Court. Pursuant to 28 U.S.C. § 2001, bona fide offers that exceed the sale price by 10% must be submitted to the Receiver within 10 days of the publication of this notice. All offers or inquiries regarding the property or its sale should be made to the Receiver at 114 Turner St. Clearwater, FL 33756. Telephone: (727) 235-6769. Email: Burt@BurtonWWiandPA.com.

★ ★ ★ ★
Garage Sales work!
Make some money for your honey.
★ ★ ★ ★

Public Notices

1-800-Pack-Rat (TN-Nashville-6252)
432 Harding Industrial Drive
Nashville, TN 37211
877-774-1537
Notice of Sale

Tenant:	Unit #
Brooks, Jeanne	ZM1645
Cannon, Lakeisha	803196
Jackson, Linda	803031
Johnson, Maxine	B60041
Janes, Angela	D62043
Janes, Angela	D64109
Matthews, Rinaud	703343
Wollen, Aimee	B60362
Wollen, Aimee	701393
Michael Gonzalez (LDM)	D01554

1-800-Pack-Rat (TN-Nashville-6252), 432 Harding Industrial Drive, Nashville, TN 37211, has possessory lien on all of the goods stored in the units above. All these items of personal property are being sold pursuant to the assertion of the lien on 10/10/2022 at 10:00 AM in order to collect the amounts due from you. The sale will take place on www.storagetreasures.com from 10/10/2022 to 10/17/2022 at 12:00 PM

Public Notices

0005426653

PUBLIC NOTICE FOR OCTOBER 2022
Notice of Public Meetings and Public Comment Opportunities related to the Greater Nashville Regional Council (GNRC) and its Boards and Committees

Public Meetings
Notice is hereby given that the following will meet during regular sessions for the purposes of considering and transacting business on behalf of the GNRC and its membership.

- **Regional Council (RC)** – The RC is the governing body for GNRC. It will meet at the Tennessee State Library and Archives, 1001 Rep. John Lewis Way N, Nashville, TN 37219 on Oct. 19 at 10:15 a.m. to conduct business on behalf of its local government members.
- **Mid-Cumberland Area Development Corporation Board of Directors (MADC)** – MADC is a federally recognized Certified Development Company administered by GNRC. It will meet at 220 Athens Way, Suite 200, Nashville, TN 37228 on Oct. 20 at 10:30 a.m. to conduct regular business related to the approval of small business loans backed with federal resources.

Further notice is given that the most up-to-date information about these and other public meetings is posted online at www.gnrc.org. Please check the website or call 615-862-8828 for the latest information about public meeting times and locations or other items of public notice.

Opportunity for Public Comment
GNRC is seeking public review and comment on the following item(s). Comments may be submitted in writing by email to comments@gnrc.org. Please include the document name in the subject line. Items will be posted for review at https://www.gnrc.org/PublicNotices.

- **Transportation Improvement Program (TIP)** – The TIP is a federally required program of projects that identifies regionally significant and federally-funded improvements to area roadways and intersections, public transit, and bicycle and pedestrian facilities across the planning area of the Nashville Metropolitan Planning Organization. In addition, the TIP satisfies the public participation requirements for the program of projects for WeGo Public Transit, the Franklin Transit Authority, and the Murfreesboro Rover. The GNRC Transportation Policy Board will consider the adoption of the proposed TIP for federal fiscal years 2023 thru 2026 at a public hearing held in conjunction with its meeting on November 16. A copy of the draft document will be available online for public comment no later than October 26.

About the GNRC
GNRC is established by the TN General Assembly as an association of local governments empowered to convene local and state leaders for the purposes of planning and programming state and federal investments into a range of social services and public infrastructure projects. GNRC serves as the region's federally recognized Metropolitan Planning Organization (MPO), Area Agency on Aging and Disability (AAAD), and Economic Development District (EDD). GNRC does not discriminate on the basis of race, color, religion, sex (including pregnancy, gender identity, and sexual orientation), family status, national origin, age, disability, genetic information (including family medical history), political affiliation, military service, or limited English proficiency. Complaints or requests for accommodation should be directed to Grant Kehler, Non-Discrimination Coordinator, 220 Athens Way, Suite 200, Nashville, TN 37228, phone number 615-862-8828.

Public Notices

0005427569

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Public Notices

0005427173

NOTICE OF MEETING AND PUBLIC HEARINGS

THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF THE METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY, TENNESSEE (the "Board"), will meet in public session at 3:30 p.m. local time, on Wednesday, October 5, 2022 in Metropolitan County Council Committee Room No. 2, 2nd Floor, in the Metropolitan Courthouse, 1 Public Square, Nashville, Tennessee, for the purpose of considering and transacting all business which may properly come before the Board, such business to include, but not necessarily be limited to, the following:

1. The request of Ewing Heights, LP, a Tennessee limited partnership, for an amendment to increase the amount of the preliminary approval of the issuance of multifamily housing revenue bonds, in one or more series (the "Ewing Heights Bonds"), previously approved by the Board in an amount not to exceed $35,000,000 to $43,000,000, the proceeds of the sale thereof to be loaned to Ewing Heights, LP, to finance the acquisition, construction, and equipping of an approximately 180 unit multifamily housing facility to be located at or near 334 Ewing Drive, Nashville, Davidson County, Tennessee 37207 (the "Ewing Heights Project"). Ewing Heights, LP will be the owner and operator of the Ewing Heights Project to be financed with the proceeds of the Ewing Heights Bonds.
2. The request of Shelby House 1, LP, a Tennessee limited partnership, for an amendment to extend the term of its preliminary approval and to increase the amount of the preliminary approval of the issuance of multifamily housing revenue bonds, in one or more series (the "Shelby House Bonds"), previously approved by the Board in an amount not to exceed $35,000,000 to $37,000,000, the proceeds of the sale thereof to be loaned to Shelby House 1, LP, to finance the acquisition, construction, and equipping of an approximately 193 unit multifamily housing facility to be located at or near 405 South 4th Street, Nashville, Davidson County, Tennessee 37206 (the "Shelby House Project"). Shelby House 1, LP will be the owner and operator of the Shelby House Project to be financed with the proceeds of the Shelby House Bonds.
3. The request of St. Mary's Senior, LP, a Tennessee limited partnership, for preliminary approval of the issuance of not to exceed $45,000,000 multifamily housing revenue bonds, in one or more series (the "St. Mary's Bonds"), the proceeds of the sale thereof to be loaned to St. Mary's Senior, LP, to finance the acquisition, construction, and equipping of an approximately 214 unit senior living rental housing facility to be located at or near 30 White Bridge Pike, Nashville, Davidson County, Tennessee 37205 (the "St. Mary's Project"). St. Mary's Senior, LP will be the owner and operator of the St. Mary's Project to be financed with the proceeds of the St. Mary's Bonds.
4. The request of Charter Village Preservation, L.P., a New York limited partnership, for preliminary approval of the issuance of not to exceed $40,000,000 multifamily housing revenue bonds, in one or more series (the "Charter Village Bonds"), the proceeds of the sale thereof to be loaned to Charter Village Preservation, L.P., to finance the acquisition, rehabilitation, and equipping of an approximately 250 unit multifamily housing facility located at or near 333 Rio Vista Drive, Madison, Davidson County, Tennessee 37115 (the "Charter Village Project"). Charter Village Preservation, L.P. will be the owner and operator of the Charter Village Project to be financed with the proceeds of the Charter Village Bonds.
5. The request of Elmington Capital Group, LLC for preliminary approval of a payment in lieu of tax agreement in connection with the construction of 118 units of multifamily housing at 75% AMI in a 296 unit development, to be located at or near 1430 Hillside Avenue, Nashville, Davidson County, Tennessee 37203.
6. The request of The Clear Blue Company for preliminary approval of a payment in lieu of tax agreement in connection with the construction of 40 units of multifamily housing at 75% AMI in a 97 unit development, to be located at or near 301 Ben Allen Road, Nashville, Davidson County, Tennessee 37207.
7. The request of Plunkett Development for preliminary approval of a payment in lieu of tax agreement in connection with the construction of 96 units of multifamily housing at 75% AMI in a 240 unit development, to be located at or near 612 Due West Avenue, Madison, Davidson County, Tennessee 37115.
8. The request of Elmington Capital Group, LLC for preliminary approval of a payment in lieu of tax agreement in connection with the construction of 114 units of multifamily housing at 75% AMI in a 286 unit development, to be located at or near 583 Bell Road, Antioch, Davidson County, Tennessee 37013.
9. The request of Giarratana, LLC for preliminary approval of a payment in lieu of tax agreement in connection with the construction of 100 units of multifamily housing at 75% AMI in a 250 unit development, to be located at or near 901 Dr. Martin L. King Jr. Boulevard, Nashville, Davidson County, Tennessee 37203.

Public hearings (pursuant to Section 147(f) of the Internal Revenue Code of 1986, as amended) ("TEFRA Hearings") will be held at the above scheduled meeting by the Board in connection with the issuance of the Ewing Heights Bonds and the location and nature of the Ewing Heights Project, the issuance of the Shelby House Bonds and the location and nature of the Shelby House Project, the issuance of the St. Mary's Bonds and the location and nature of the St. Mary's Project, and the issuance of the Charter Village Bonds and the location and nature of the Charter Village Project. At such public hearings there will be an opportunity for persons to express their views concerning the foregoing. Anyone may speak at such public hearings or submit written comments to be considered thereat. Persons wishing to participate should submit a written request to speak to Cynthia M. Barnett, counsel to the Board, at the below address at least 24 hours prior to the public hearings.

Additional information concerning the above may be obtained from, and written comments should be addressed to, Ms. Cynthia M. Barnett, Adams and Reese LLP, 1600 West End Avenue, Suite 1400, Nashville, Tennessee 37203, email cindy.barnett@arlaw.com, telephone number (615) 259-1454.

Stephen L. Meyer, Chairman

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All classified ads are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Tennessean reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Tennessean shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

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Domestic Pets



We have adorable Maine coon kittens available. Both male and female, up to date on shots, trained and home raised with great temperament. Call/text (205) 851-4047 for more inquiries

Yorkshire Terriers, Yorkie Poo, Cockapoo, $700. UTD shots, worming Well socialized. Call/text 615-415-2769

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Domestic Pets



Aussie Doodle Puppies. 10 weeks old, $1100 931-446-5965

AUSTRALIAN SHEPHERD puppies, toy 2 reg. red tri males. Born 7/4/22. Shots & wormed UTD. $400. 931-629-9102

Domestic Pets

Beagle pups 7 wks, males $200, females $250, incls 1st shot & free bag of feed. Call Billy 901-626-5822



Bernedoodle Puppies, Bernedoodle, Male and Female, , 5 Weeks, Tricolar - Black, White, Brown. Affectionate, relaxed, cuddly, playful, loyal, intelligent We have a litter of beautiful F2 Standard Bernedoodles ready to go home on Oct 6. We also have a litter of adorable F2 Mini Bernedoodles that will be ready on Oct 16. These puppies are hypoallergenic and low shed, and will have soft, wavy to curly fur with great coloration. Bernedoodles are known for their wonderful temperaments and are perfect as a family dog. Please see our website, bainfamilybernedoodles.com, for more information and pictures. We are in Fayetteville, TN. $$2000 (256)508-4236 keithandfricia@bainfamilybernedoodles.com

Bichon Puppies: CKC registered, 13 weeks, 1st shots, dewormed, Girls: $1,000, Boys: $850. Call: 615-585-1067

Domestic Pets

Beautiful

Boxer puppies with papers, 256-349-0247

German Shepard, AKC, Pup Looking for a Fur-ever Friend? Short Haired Black & Tan M/F Avail. Raised around Kids and other German Shepard's & inter acted with daily. Wormed & up to date on all shots. Call Ruth 615 969 063

Goldendoodle Puppies - Black w/white markings, CKC registered, vet chkd, shots & wormed. $800. ea. 931-212-0380

SHIH-POO PUPPIES- Males & Females., 8 wks, 1st shots & wormed, pad trained. $300. 615-578-3809



Standard Goldendoodle puppies born 8/22, ready 10/17, vet ck'd, shots & dewormed. $850 or make offer. Call or text 270-666-1810

Domestic Pets

Toy Australian Shepherd Puppies 2M/1F, 11 wks, Champion bloodlines, Purebred, UTD shots/wormer, genetic testing through parentage, tail/dews, registered, Bred in home. Ready now, www.bodicanminiaussies.com $2700 (518)495-5272 juney2kmom@aol.com

Wanted: Adult Male Rottweiler Will live on Farm. Great Loving Home Call: 931-625-1220 Leave Message

Assorted
Merch
all kinds of things...

General Merchandise

John Deer Riding Mower- 42-inch cut. $450 obo. Cub cadet zero turn- 50-inch cut. $950 obo. Grandfather Clock- made in Galatin, TN by Ramcraft. $350 obo. 615-417-0408

OAK DINING ROOM SET
6 chairs, credenza & hutch. $800

Wanted to Buy

WANTED- Silver Eagles, Gold, Silver Platinum Coins, Rare Coins, Pre-1972 Baseball cards, etc. 615-497-9852

Wanted to Buy



INSTANT CASH PAID for baseball cards, sports memorabilia, autographs, game used sports items, coins, gold, silver, watches, diamonds, old toys, trains, comic books, old photos, military, presidential, huge collections, lots of others. Scott, 513-295-5634 Instant Cash Paid - goodasgold@roadrunner.com

Automotive
Cars
best deal for you...

Autos Wanted

123 recycling WE BUY JUNK CARS , we also pickup free ones in the way, (615)935-5023

Cars

Lincln 2019 MKC - Only 19,000 actual miles, absolute mint cond, just like showroom new. Black w/black leather, private owner, must sell soon. $22,731. 615-330-1500

Place your ad online @ www.tennessean.com

STATE OF TENNESSEE
COUNTY OF OBION

Personally appeared before me, the undersigned Notary Public for Obion County, Tennessee, David Critchlow, who on oath says he is the publisher of the Union City Daily Messenger, a daily newspaper of general circulation, published at Union City in said county and state, and that the hereto attached

Notice of Change in the TennCare Program

Notice was published in said paper for 1 days/weeks as follows

9/29, _____, _____, _____, 2022

Publisher, [redacted]

Publisher's Fee $ 314.42

Subscribed and sworn to me this 29 day of September, 2022.

Notary Public [redacted]
Commission expires July 24, 2024

DONNA L. GIBSON
STATE OF TENNESSEE NOTARY PUBLIC
OBION COUNTY

CLASSIFIEDS

Misc. For Sale • Services • Real Estate • Help Wanted

Appliances

FOR SALE: Whirlpool side by side refrigerator, white, runs good, $200 OBO, 731-364-2934, leave name and number

Satellites

DIRECTV SATELLITE TV Service Starting at $74.99/month! Free Installation! 160+ channels available. Call Now to Get the Most Sports & Entertainment on TV! 855-337-0568 (TnScan)

DISH NETWORK. $59.99 for 190 Channels! Blazing Fast Internet, $19.99/mo. (where available.) Switch & Get a FREE $100 Visa Gift Card. FREE Voice Remote. FREE HD DVR. FREE Streaming on ALL Devices. Call today! 1-844-274-6074 (TnScan)

TROUBLE HEARING your TV? Try TV EARS' Voice Clarifying Wireless TV Speaker. Better than a soundbar and/or turning the TV volume way up. Special, limited time $50 off offer. Call TV Ears. Use code MBSP50. Call 1-844-366-5059 (TnScan)

Health

ATTENTION VIAGRA users: Generic 100 mg blue pills or generic 20 mg yellow pills. Get 45 plus 5 free $99 + S/H. Guaranteed, no prescription necessary. Call Today 1-877-707-5707 (TnScan)

Want to Buy

TOP CA$H PAID FOR OLD GUITARS! 1920-1980 Gibson, Martin, Fender, Gretsch, Epiphone, Guild, Mosrite, Rickenbacker, Prairie State, D'Angelico, Stromberg. And Gibson Mandolins/Banjos. 866-846-4260 (TnScan)



Notice

NOTICE
The Messenger screens all classified ads prior to publishing in order to protect our readers from scams.

Our customers are important to us. If you see an ad that you are unsure of or if you respond to an ad that is a scam, please contact us.

The Messenger Classifieds Department 731-885-0744

Legal

NOTICE
TITLE VI SECTION 504
TO WHOM IT MAY CONCERN

It is the policy of the Waters of Union City to operate in compliance with title VI of Civil Rights Act and Section 504. Admission to and employment at this facility, service rendered by or through this facility are provided without regard to race, national origin, religion or handicapped condition.

These same requirements apply to all patients' room assignments, staff assignments and transfers within the facility. This is no distinction in eligibility for or in the manner providing and patient service by or through the nursing home. This applies to physicians and other health care professionals whose right it is to attend patients here.

All persons or organizations that have occasion to either refer persons for admission or to recommend this facility are advised to do so without regard to the person's race, color, national origin, religion, or handicap.

9/15/2022, 9/20/2022, 9/22/2022, 9/27/2022, 9/28/2022

NOTICE OF SUBSTITUTE TRUSTEE`S FORECLOSURE SALE

WHEREAS, Teodoro Abundis Gonzalez and Petra Macias Gonzalez and Abel Gonzalez executed a Deed of Trust to John C Clark, Trustee for the benefit of Mortgage Electronic Registration systems, Inc., as nominee for First State Bank, on May 26, 2004 and recorded on May 28, 2004 in Book 67-B, Page 587 in the Office of the Register of Obion County, Tennessee.

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust JP MORGAN CHASE BANK, NATIONAL ASSOCIATION (the "Holder"), appointed the undersigned, McMichael Taylor Gray, LLC, as Substitute Trustee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, McMichael Taylor Gray LLC, Substitute Trustee, by virtue of the power and authority vested in it, will on October 20, 2022, at 1:00 PM(CST) at 6 Bill Burnette Circle, Union City , TN 38261 at the Obion County Courthouse, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Obion County, TN:

Beginning at a stake in the south boundary line of Watson Street, the same being 90 feet west of the northwest corner of the Billy W. Blackley lots, runs thence West 90 feet to a stake in the south boundary line of Watson Street, the same being the northeast corner of A. J. Cryer lots (now Billy Brown); runs thence South, along the east boundary line of the Cryer lots, 225 feet to a stake in the north boundary line of the John F. Williams land; runs thence East, along the north boundary line of the Williams land, 90 feet to a stake, the same being 90 feet west of the southwest corner of the Billy W. Blackley lots; runs thence North 225 feet to the point of beginning.

BEING identified for tax purposes as Map 123-L, Group F, Parcel 3.00, with an address of 506 Watson Street, Obion, TN 38240.

BEING the same property acquired by Teodoro Abundis Gonzales and wife, Petra Macias Gonzales, and Abel Gonzales, by deed dated this date, of record in Deed Book 26-N page 633-634 the Register's Office of Obion County, Tennessee.

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust JP MORGAN CHASE BANK, NATIONAL ASSOCIATION (the "Holder"), appointed the undersigned, McMichael Taylor Gray, LLC, as Substitute Trustee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, McMichael Taylor Gray LLC, Substitute Trustee, by virtue of the power and authority vested in it, will on October 20, 2022, at 1:00 PM(CST) at 6 Bill Burnette Circle, Union City , TN 38261 at the Obion County Courthouse, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Obion County, TN:

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Street Address: 506 Watson Street, Obion, TN 38240
Parcel Number: 123L F 003.00
Current Owner: Abel Gonzales and Liliana Judith Plascenia Gonzales
Other Interested Party(ies): Liliana Judith Plascenia Gonzales

If the United States or the State of Tennessee have any liens or claimed lien(s) on the Property, and are named herein as interested parties, timely notice has been given to the applicable governmental entity, and the sale will be subject to any applicable rights of redemption held by the entity as required by 26 U.S.C. § 7425 and/or Tennessee Code § 67-1-1433

This sale is subject to all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory rights of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; any matter that an accurate survey of the premises might disclose; any prior liens or encumbrances as well as any priority created by a fixture filing; any deed of trust; and any matter that an accurate survey of the premises might disclose; and

All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust. The undersigned will sell and convey only as Substitute Trustee. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substitute Trustee at any time.

This office is attempting to collect a debt. Any information obtained will be used for that purpose.

McMichael Taylor Gray LLC
Substitute Trustee
3550 Engineering Drive
Suite 260
Peachtree Corners, GA 30092
Office: 404-474-7149
Fax: 404-745-8121
MTG File No.: TN2022-00180

9/22/2022, 9/29/2022, 10/6/2022, 10/13/2022



BID NOTICE

Obion County is accepting bids for a concrete building pad sized 96 x 50 at the Obion County EMA office located at 1700 N. 5th Street, Union City, TN 38261. Building pad should be 4,000 PSI concrete with fiber and re-bar. Contractor will also need to prepare pad site. Complete bid packets containing bid specs and examples may be obtained from the Obion County Mayor's Office. For more information or request an electronic bid packet, call 731-885-8580 or email ocp@obioncountytn.gov. Obion County Government reserves the right to accept and/or reject any and all bids in whole or in part and to waive any irregularities in any bid. Bids must be received before and the public bid opening will be at 1 pm, Tuesday, October 11, 2022, at the Obion County Mayor's Office, 316 S. 3rd Street, Union City, TN 38261.

BID NOTICE

Obion County is accepting bids for renovation of the Obion County Satellite Office (Drive Thru) located at 324 S. 1st Street, Union City, TN 38261. Renovation shall include a drive thru lane conversion and a new roof on the office building. Lane conversion consists of reducing the drive through from a three lane to a two-lane bay. Complete bid packet containing bid specs may be obtained from the Obion County Mayor's Office. Call 731-885-8580 or email ocp@obioncountytn.gov for more information or request an electronic bid packet. Obion County Government reserves the right to accept and/or reject any and all bids in whole or in part and to waive any irregularities in any bid. Bids must be received before and the public bid opening at 2 pm, Tuesday, October 11, 2022, at the Obion County Mayor's Office, 316 S. 3rd Street, Union City, TN 38261.

BID NOTICE

The Town of Hornbeak seeks to retain the services of a professional consultant firm to advise the city on complying with ARPA requirements for all city ARPA activity.

The city is requesting qualification-based proposals for ARPA consultant services to be submitted to Betty Walley at Hornbeak City Hall on or before Monday October 5th, 2022, at 4:00pm.

For more information, please contact Town of Hornbeak city hall office at 212 West Main Street Hornbeak, TN 38232 (731) 538-9626

9/29/2022, 10/4/2022

Legal

NOTICE OF PUBLIC MEETING

The Union City Board of Zoning Appeals does hereby give public notice of a regular meeting to be held on Friday, October 7, 2022, at 8:30 AM in the courtroom of the Municipal Building located at 408 S. Depot St. for a side yard variance request for the property at 924 S Third Street. A copy of the request may be viewed in the office of the Building Inspector during regular business hours. All interested parties are invited and encouraged to attend. It is the policy of the City of Union City, Tennessee not to discriminate on the basis of race, color, national origin, age, sex or disability in its hiring and employment practices, or in admission to, access to, or operation of its programs, services, and activities. If special accommodations are needed in order to fully participate in this meeting, please contact City Hall at least 48 hours in advance.

9/29/2022

Advertise with Messenger Classifieds 731-885-0744

Notice of Change In the TennCare Program Coverage of Dental Services for Adults

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare Demonstration, of a planned change to the TennCare program. This change entails enhancements to the benefits available to adults enrolled in TennCare. This notice is provided in order to solicit public input on this planned change.

Currently, TennCare covers dental services for children under age 21, for pregnant and postpartum adults, and for certain adults receiving long-term services and supports from TennCare. Dental services are not currently covered for most adults enrolled in TennCare.

Effective January 1, 2023, TennCare will cover dental services for all adults enrolled in TennCare. Dental services for adults will be furnished by the dental benefits manager (DBM) under contract with TennCare to administer dental services to TennCare members. Dental benefits covered for adults age 21 and older will include services from the following categories: diagnostic x-rays and exams; preventive cleanings; topical fluoride treatments and caries arresting medicament; restorative (fillings); endodontics; scaling and root planing; full mouth debridement; crowns; partial dentures; complete dentures; immediate complete dentures and complete denture relines; tooth extractions; alveoloplasty; removal of lateral exostosis; removal of torus palatinus; removal of torus mandibularis; palliative treatment; and nitrous oxide inhalation sedation.

This change will not result in the enrollment of additional persons in the TennCare program. The coverage of dental services for adults is expected to result in an increase in annual aggregate expenditures of approximately $75.5 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/AdultDentalComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.penncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. In order to be considered prior to implementation of these changes, feedback must be received no later than October 24, 2022.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

• A public hearing will be held electronically on October 7, 2022, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at https://tngov.webex.com/meet/JReeve on the morning of October 7, 2022.

• A public hearing will be held in person on October 10, 2022, at 2:00 p.m. CT in Room 1 East A of the TennCare Building, 310 Great Circle Road in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

9/29/2022

Advertise with Messenger Classifieds 731-885-0744

It is the policy of The Messenger that all advertising for the sale, rental or financing of residential real estate advertising appearing herein comply with the Federal Fair Housing Act which prohibits "any preference, limitation, discrimination because of race, color, religion, sex, handicap, familial status, or national origin, or intention to make any such preference, limitation or discrimination." In addition, the Human Rights Act prohibits such discrimination. No advertising for the sale, rental or financing of residential real estate will be refused or rejected because of race, color, religion, sex handicap, familial status or origin.

It is also the policy of this newspaper not to require different charges or terms for such advertising because of race, color, religion, sex, handicap, familial status or national origin.

For Rent

REASONABLE RENT:

2-3 Bedroom houses

Duplexes

2 Bedroom Apartments

I BUY HOUSES

RALPH ADAMS
731-885-2100

Help Wanted

NOW HIRING: Tooling, Process Technicians, Production, Maintenance, Warehouse and Distribution. $500 Hiring Bonus! Benefits in 30 Days! MEDEGEN Medical Products, Gallaway, TN 901-867-4263 www.medegenmed.com (TnScan)

Truck Drivers

NEED YOUR CDL? We do CDL Training, testing, Job placement. Company paid training available. Training at 119 EL Morgan Dr. Jackson, TN or 6711 Reese Road, Memphis, TN. Call 800-423-8820 Or visit www.drive-train.org (TnScan)

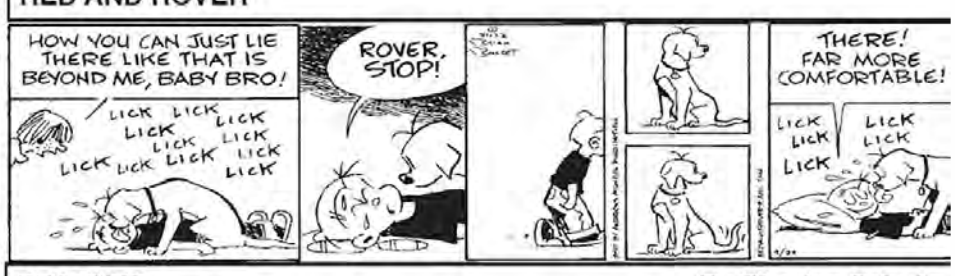






COMICS

RED AND ROVER — By Brian Basset



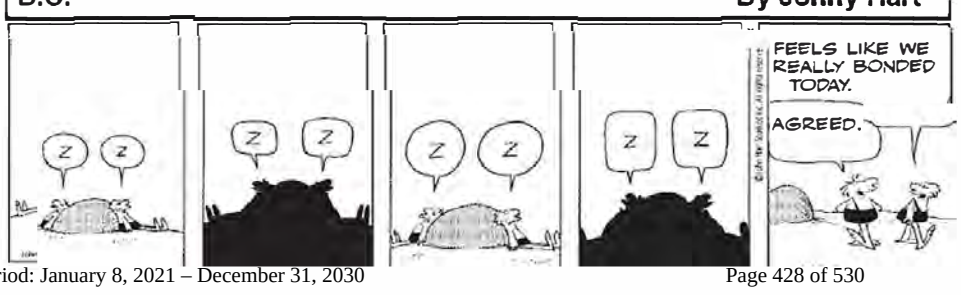
PEANUTS — By Charles Schulz



GARFIELD — By Jim Davis



B.C. — By Jonny Hart



Attachment D

Public Comments

From: [redacted]
Sent: Wednesday, October 12, 2022 2:47 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental Benefits for adults over 21

I have prayed for this. Thank you, you may have saved my sister's life. She has a really bad gum disease and no way of working to get coverage so this was a blessing.

From: [redacted]
Sent: Wednesday, October 19, 2022 8:23 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental Services (TENNCARE)

Good morning!

First, let me just say thank you for allowing the public, especially those who are enrolled in a Tenncare plan, to voice our concerns or appreciation when it is needed. So, Thank You!

Now, I am one of the "enrolled" and am taking this opportunity to express my gratitude to all those who have decided to expand dental services to Adults. After reading the public report on the Tenncare website, it sounds as if this is a concrete decision that will take affect next year...if that is actually the case, I am happy to voice my excitement and appreciation to whomever is responsible. As someone who hasn't been so lucky when it comes to anything dental and would love nothing more to have an actual smile, believe me when I say, that I am very EXCITED & very, very GRATEFUL!! Again, thank you for this opportunity and I hope there are many more voices this happy that follows. 😊

Alycia Milner
931-802-0999

From: [redacted]
Sent: Monday, October 17, 2022 12:45 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental Coverage for Adults 21+

I vote an empathic YES!! I am a diabetic with hypertension and a rare immuno-related disease known as Dercum's Disease and my teeth are terrible from the multiple surgeries since I was 18 years old. The RAM clinics are a wonderful service but the need is overwhelming and the cost outrageous to have a confident smile. Everyone deserves this change and I can not wait to make my appointment to fix my teeth. I am in dire need of a full extraction and upper and lower dentures that would result in a $4000-$8000 expenditure that would take me years on a payment plan to achieve. So many people are judgemental of someone with bad teeth assuming the worst of their character and all people deserve this!! Periodontal care is imperative to cardiac health as well as every portion of your bodies health! This would, I believe, effectually allow for the decline of so many other health issues that stem from poor oral care and as a community we can rise together. I am as excited as a child on Christmas day and can not wait to smile without fear of stares and judgements being made. Thankfully and emotionally written,
Amanda J. Maddle

From: [redacted]
Sent: Thursday, October 13, 2022 10:52 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental services for adults

Please consider this. After having two kids my teeth are worse than they have ever been. They are cracking. I can't afford to get them fixed so just have to keep getting them pulled. The healthcare and dental system in America is crazy. It needs to be re-evaluated. My kids look at my teeth and don't understand. I tell them they need to brush theirs but it doesn't do any good with they see me in so much pain. Not from drugs or bad hygiene. Just from having kids

From: [redacted]
Sent: Thursday, October 6, 2022 8:50 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Tenncare dental

Hello,
I am a Tenncare patient and I think it is awesome that they will now be giving adults who are 21 and over dental coverage. I am currently having dental problems that I need to take care of immediately and I have not been able to do so because I haven't had dental insurance.. I think that Tenncare should have offered dental insurance to adults a long time ago because dental health is a very important part of your overall health. You can literally die from dental problems.. I currently have an abscess tooth that needs a root canal and I cannot afford a root canal so I have to have my tooth pulled which is unfortunate..

Sent from my iPhone

From: [redacted]
Sent: Monday, September 26, 2022 11:20 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Provider Concerns

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

To whom it may concern,
Currently, TennCare women who are pre-natal or post-natal have dental coverage however, very little to no dentist will serve this population. I am a family support specialist and have tried to assist moms in finding a dental provider. When we call the TennCare or Dentaquest help number they give providers that no longer provide TennCare services. Finding a dental provider in the Sullivan County doesn't exist. Either they don't accept TennCare anymore or are filled. The only dental provider I can find in our area is Gray Station Dental.

Please if all possible when you update TennCare changes please update the service providers as well.

Warm Regards,

Angela McGee, BS
Family Support Specialist/Healthy Families EBHV Program
Sullivan County Health Department
Office: 423-279-2860
Work: 423-361-8950

Healthy Families Tennessee

Sullivan County Regional Health Department
Mission: To improve the health status of Sullivan County citizens through education and service.
Vision: Inspiring our community to healthier lives

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From: [redacted]
Sent: Tuesday, October 25, 2022 12:43 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental

The new dental plan for adults as well for all is going to greatly increase my health physically and mentally. We need this so much!

Ashley Bradshaw

Sent from my iPhone

From: [redacted]
Sent: Tuesday, October 18, 2022 6:20 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] TennCare planned dental change

I don’t know if I’m doing this the right way but I just want to say that if this change goes through, the lives of so so many would be impacted and changed astronomically for the better. I cannot express what it would mean to me and my life to get to go to the dentist. I haven’t been in over 6 years and my teeth are declining rapidly. I don’t think I could ever pay for the services outright myself, so it’s either let my teeth rot out and barely pay my utilities; or skip out on water and power and fix one or two teeth at most. This is absolutely an amazing step for those of us desperate for help! Thank you so much for the consideration, best regards. - Ashley

From: [redacted]
Sent: Sunday, October 9, 2022 7:53 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL]

Do you have to have a certain insurance. I have ameriagroup for tenncare

From: [redacted]
Sent: Friday, October 21, 2022 4:06 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental coverage

PLEASE include dental for those over 21! I have six rotting teeth in my mouth countless fillings and have 4 impacted wisdom teeth and can't do anything about it because I can't afford it. I cry every day because of how bad it hurts. Please help people like me. Im only 22, I just have bad teeth genes from my mother. Im crying as I type this. I need this.

Sent from my iPhone

From: [redacted]
Sent: Friday, October 7, 2022 9:38 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] This should have been done long ago, thank you. It has to do with health and it's very expensive. Vision benefits should be next.

Sent from my iPhone

From: [redacted]
Sent: Tuesday, October 11, 2022 4:58 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental with tenncare

This a wonderful news.
Elizabeth Pozo Mazzarella
682 farner rd
Farner tn 37333

Sent from my iPhone

From: [redacted]
Sent: Tuesday, October 18, 2022 11:06 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Questions

Hello my name is Hannah Blankenbeckler. I have a couple questions about the Notice Change of Dental Services for Adults. So as of right now I'm only covered on Tenncare because I just had a baby on June 23 2022. So I'm covered for my dental until my baby is a year old, correct? My dentist office told me that my Tenncare only covered my x-rays, teeth cleaning, and my fillings. As of right now I am scheduled to get my wisdom teeth removed on November 10th. But when I was at the dentist on Monday October 10th they said that they might not even be able to do them since the sedation isn't covered by Tenncare. I just can't afford it with a newborn and 2 year old. Anyways my question is should I wait? They said they were going to numb me and use nitrous but now they are saying that the guy that does it might not even do it now with me awake.

Hannah Blankenbeckler
Please Call if it's easier
815-374-0693

From: [redacted]
Sent: Thursday, September 29, 2022 4:25 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL]

I believe this new change with approved Tenncare dental coverage is going to make a BIG IMPACT on our country I know so many individuals struggling to make ends meet that there is no way that dental work could be on their budget list & im one of those struggling individual that need so badly to have my teeth fixed so I can make a difference in my life & then can go out & make a difference in this Great Big World if Ours! Being able to smile or laugh or maybe even just to be able to talk & interact with other human beings & not be embarrassed about the way our teeth look & not to mention the pain that you endure with teeth pain with no way of getting any dental help without having money that so many of us just don't have..so this is truly A GREAT BIG BLESSING! so THANK YOU TO ALL THE GREAT PEOPLE that imposed & voted for the poor people to be able to have a shot at this beautiful life with confidence now due to this AWESOME FUNDING!! Truly A Gift from God I'm So Excited I can't even sleep & it's 4 in the morning I've been reading all about it & just keep picturing the endless possibilities that await our new & improved universe!!🙏

Heather Milen

From: [redacted]
Sent: Wednesday, October 19, 2022 8:30 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental insurance.

I would love to have dental insurance. I am a mother of 2, I have been missing on of my front teeth, and a screw dangling out the other, I have constant infections, abscesses, and bleeding from my gums. If this passes I'll be able to get all of this fixed. I've been appraised for 20,000 to fix it by myself. With this insurance my whole life would change. I've developed eating disorders due to not being able to bite down in most areas of my mouth. I can't eat chips, burgers, hot dogs in a bun the list goes on! Please for people like me. Approve this!

Sent from my iPhone

From: [redacted]
Sent: Thursday, September 29, 2022 12:52 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL]

Thank You so much for finally helping adults w/ Dental needs! I wish that Dental Implants would be covered as well, for those as myself that dont need or want all teeth removed for Dentures. I just need 2Implants, I hate to pull all my teeth for just 2missing? If that could be considered, I would be so grateful! Not having Dental benefits & cannot afford them, this makes me so Happy! This problem has held me back recently & now, hopefully w/new confidence I can overcome those fears!! Thank You again... Jacqulyn Conway, 41yrs old, mother of 14yr old son. Hamilton County, TN 37343

Jacqulyn Conway

From: [redacted]
Sent: Wednesday, September 28, 2022 12:29 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Tenncare Dental changes

Hello I'm Jaleesa Catlett. I do believe adults should have dental coverage under tenncare. I developed gum disease at a time when I no had dental coverage but couldn't afford my own dental insurance or to pay out of pocket.

I hope my opinion is taken into consideration.

Sent from my iPhone

From: [redacted]
Sent: Sunday, October 9, 2022 10:12 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Thank you so much!

I literally just cried when I saw that dental benefits would be included in TennCare coverage! I had just begun looking into dental coverage. I am so happy for this addition!

Sincerely,
Jeanie Garrell
--
Jeanie

From: [redacted]
Sent: Wednesday, October 19, 2022 3:06 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] viewing comments

Hello, I read with great appreciate the expansion of dental benefits to all adults on TennCare. I am writing to request access to view the public comments being submitted in relation to this issue.

These instructions were in the pdf announcement and I am following them to the best of my ability!

“Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.”

Please let me know what else needs to be done to view the public comments.

Thanks,
Jonathan

Jonathan Rodgers
CHANT Care Coordinator
~~~~~~~~~~~~~~~~~~~
(C)ommunity (H)ealth (A)ccess and (N)avigation in (T)ennessee
615.588.7499 (m) 615.313.9142 (f) 615.340.0433 (o)
~~~~~~~~~~~~~~~~~~~

From: [redacted]
Sent: Monday, October 10, 2022 8:45 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] New Dental Plan

To whom it may concern:

Hi I'm Justin, currently enrolled in with tencare/bluecare. I understand as of January 1 2023 we will have dental insurance available to us. Is there anything I need to do ahead of time or signup? I have had issues with my teeth since I was a child, and the current state has taken a toll on my health. I battle constant/daily infections, teeth have broken off, gums are really sore and inflamed, unable to chew majority or food, and I'm in constant pain. I'd like to be able to use the dental insurance immediately once it takes effect with having to wait more time.

From: [redacted]
Sent: Friday, October 14, 2022 5:24 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Regarding Tenncare's Proposed Dental Change

To whom it may concern,

I would like to take this opportunity to voice my opinion about Tenncare's proposed dental change. I think this is a great idea for all adults to have access to dental coverage. A lot of children and adults have untreated dental problems and other health issues due to the expensive cost of dental work. As a low income stay at home mother of young kids, I love this plan, and it will greatly benefit my family and other low income families as well.

Sincerely,
Katelynn

From: [redacted]
Sent: Thursday, October 20, 2022 12:03 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] About the adult dental change

Thank YOU!!! THIS SI A CHANGE THAT IS GOOD!!!

From: [redacted]
Sent: Sunday, October 16, 2022 10:09 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] HELLO

I seen where in January 1, 2023 adults with insurance gets free dental. I have Amerigroup and was wondering if I would be covered? I AM IN DESPERATE NEED OF ALL MY TEETH CUT/PULLED OUT and dentures. I have 6 kids and extremely bad teeth. I'm turning 34 in December. I live in Gallatin TN.

From: [redacted]
Sent: Monday, October 24, 2022 3:19 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental services

It is beyond a blessing to know that now i can visit the dentist office on medicaid! If anyone objects they can go to h e double hockey sticks.

Thank you. Good day

From: [redacted]
Sent: Monday, October 17, 2022 5:35 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] This is great for the people of Tennessee.

Teeth are an essential part of healthcare and I am ecstatic that people who previously couldn't afford to care for their teeth or lack thereof, now have the possibility.

Krista Malone

From: [redacted]
Sent: Sunday, October 9, 2022 7:46 AM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Upcoming Dental Coverage for Adults 21 and over Comments

I am a 44 yr.old female who is a current member of the Tenn Care program. My 11 yr.old daughter and I have been for several years now. I just wanted to reach and First say Thank you for allowing me to have continuous medical care for the both of us. I have had many surgeries to my reproductive health since childbirth and have a pretty hard time with all of them. Second, the opportunity to even think about having dental care available to me is absolutely overwhelming in a great and wonderful way. I don't believe I was able to get that care when I was pregnant in 2010. If I was, I most certaining didn't have a clue about it. I am so very grateful for this upcoming decision the State has made to allow me to fix my teeth. Due to all my surgeries and extreme lack of finances to be able to see a dentist, I haven't been able to eat correctly(due to damage in my mouth) in a very long time. This chance that you are about to bestow upon me, will absolutely change my life and I cannot Thank You enough. I greatly appreciate the oppurtuity to have my thoughts heard and once again Thank You so very much for the ability to be able to take care of all aspects of my Health.

From: [redacted]
Sent: Tuesday, October 18, 2022 3:48 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Proposed change in TennCare dental coverage

I want to say how grateful I am for this proposed change in dental coverage for adults receiving TennCare. I have some severe tooth pain that is affecting my ability to accomplish everyday tasks.

A consultation revealed that I need several crowns, a couple fillings, and my wisdom teeth removed. With a cost of $16,000 total, there is no way I can afford to pay it on my own before more damage is done. I do take good care of my teeth, but my last few pregnancies took a toll on my dental health.

I hope to someday not need medicaid. But for now, I am beyond grateful for TennCare and am counting down the days until This change in policy that will allow me to finally get my teeth taken care of.

Than you again,
Sarah Cave

From: [redacted]
Sent: Tuesday, September 27, 2022 4:28 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL]

My name is Taylor nicole weddington and I'm 29 years old. My mother was a dental assistant My whole life I lost dental insurance at 18. I got pregnant with my daughter at 21. I wasn't prepared for what pregnancy can do to one's mouth. I hate my smile because I have half a front tooth missing and the others chipping away with them. I've broke 2 molars into pieces trying to get them out. And my teeth just keep getting worse. I can't afford to fix my mouth and I literally have problems with my confidence in the workplace. I can't stand for a customer to see my messed up mouth. I beg the state to help the mothers out here that can't be all they can be because of their smile. The pain is unexplainable but the humiliation of a messed up mouth is so much worse. Thanks for your time and I hope this helps someone in someway.

From: [redacted]
Sent: Thursday, October 20, 2022 9:05 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental Benefits Change

I would like to say that I am completely happy about this change for adults with TNcare. So many of us over 21 years old struggle with dental health, and have had no choice but to continue suffering, pay out of pocket, or pay for a dental plan. The majority of adults aren't able to access dental care with the rising cost of living, especially in todays world. I am one of the individuals over 21 who have tolerated issues with my teeth for years because I just could not pay the price for a healthy smile. I am SO grateful to potentially be able to seek help since this change is happening! I could not explain how amazing it would be to have a nice smile, and healthy teeth because of insurance finally being able to contribute to that! I sincerely hope and pray that next year I will be able to confidently ask for assistance at the dental office and not be able to worry about the cost. Thank you so much! I am ecstatic!

Sent from my iPhone

From: [redacted]
Sent: Friday, October 21, 2022 10:37 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Changes to include adult dental

Dear Sir or Madam .
All I have to say is thank you so much for this blessing..

From: [redacted]
Sent: Wednesday, October 19, 2022 3:13 PM
To: PUBLICE NOTICE TENNCARE
Subject: [EXTERNAL] Dental coverage

It took me years to afford new teeth. My mom never took me as I kid I ate a lot of candy an didn't care for them so much. It effected my life at 18 I had black spots on them humans could see kids would ask about . People assume I had a drug issue and wouldn't hire me. It was hell and depressing. I took my last tax check with all my kids an finally got them all out because it was cheaper then saving them. My son now is facing the same issues. I took him to the dentist but he never cared for his teeth till now when their rotting out. Please help these young's not to have to feel like I did.

TN Division of TennCare

October 27, 2023

Kamia Rathore
State Demonstrations Group
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Notice of Change to Coverage and Benefits under the TennCare Demonstration

Dear Ms. Rathore,

Pursuant to the terms and conditions of the TennCare Demonstration, Tennessee is providing official notice to CMS of our intent to make changes to coverage and benefits available under the Demonstration. These changes add allowable benefits and coverage, as permitted by the Demonstration's STCs.

Specifically, Tennessee intends to increase the income standard for pregnant women eligible for coverage under TennCare. Effectively, Tennessee will increase its income standard from 195 percent of the federal poverty level to 250 percent of the federal poverty level. This change is scheduled for implementation beginning January 1, 2024.

We are pleased to be able to make this enhancement to the coverage available under TennCare. This change is expected to lead to improved maternal health outcomes in Tennessee.

A fuller description of this change is attached to this letter. In addition, we have attached documentation of the state's compliance with the public notice requirements outlined in the Demonstration's STCs.

If you have any questions about this notice or if you need additional information, please contact Aaron Butler at 615.507.6448, or aaron.c.butler@tn.gov.

Sincerely,

[redacted]

Stephen Smith
Director, Division of TennCare

Attachments

Attachment A

Description of Changes to Coverage and Benefits

Description of Changes to Coverage and Benefits

The following provision related to coverage and benefits under the TennCare Demonstration will become effective on January 1, 2024.

Coverage of Pregnant Women with Incomes between 195 Percent FPL and 250 Percent FPL. Tennessee currently provides coverage for pregnant women whose modified adjusted gross income is equivalent to 195 percent of the federal poverty level or lower, consistent with 42 CFR § 435.116.

Effective January 1, 2024, TennCare will also cover pregnant women, not otherwise eligible for TennCare, whose modified adjusted gross income is higher than 195 percent of the federal poverty level, up to a maximum of 250 percent of the federal poverty level, as permitted under 42 CFR § 435.218.

Pregnant women enrolled in TennCare as a result of this change will receive coverage for the duration of their pregnancy and for 12 months following the end of pregnancy. Benefits covered for pregnant women enrolled in TennCare as a result of this change will be the same as those covered for all other TennCare enrollees. Pregnant women enrolled in TennCare as a result of this change will receive their care through TennCare's managed care service delivery system like all other TennCare enrollees.

Attachment B

Description of Public Notice and Input

Description of Public Notice and Input

Effective January 1, 2024, TennCare will cover pregnant women whose modified adjusted gross income is higher than 195 percent of the federal poverty level, up to a maximum of 250 percent of the federal poverty level. The state has taken a variety of steps to ensure that members of the public have been notified of this planned change and have had an opportunity to provide comments and input. These measures were informed by—and comply with—the STCs of the TennCare Demonstration and 42 CFR § 431.408.

Public Notice

The state held a formal notice and comment period on this proposed change to coverage and benefits from September 13, 2023, through October 13, 2023. During this time, a comprehensive description of the planned change was made available for public review and comment on a designated page on the TennCare website. An abbreviated public notice—which included a summary description of the planned change; the locations, dates, and times of two public hearings; and a link to the full public notice on the state's website—was published in the newspapers of widest circulation in Tennessee communities with 50,000 or more residents.

The state held two public hearings to seek public comment on this planned change to TennCare coverage. One hearing took place on September 26, 2023, at 2:00 p.m., Central Time, at the TennCare building, 310 Great Circle Road, Nashville, Tennessee. The other hearing was conducted virtually and took place on September 27, 2023, at 10:00 a.m., Central Time. Members of the public also had the option to submit comments throughout the notice period by mail and email.

In addition, this planned change was presented as a funding request by TennCare during the 2023 session of the Tennessee General Assembly and was approved by the General Assembly as part of the state budget through a public legislative process.

TennCare also disseminated information about this proposed change, including a link to the relevant information on TennCare's website, via its social media accounts (i.e., Facebook, Twitter/X).

Public Comments

The state received comments from one organization on this proposed change. The commenter was supportive of the proposed change and expressed the view that increasing the effective income standard for pregnant women to receive coverage (including postpartum coverage) through TennCare will support improved health outcomes, including those involving chronic and pregnancy-related conditions. This comment is attached in its entirety as Attachment D.

The state did not make any changes to its proposal based on this comment.

Attachment C

Documentation of Public Notice

Notice of Change to the TennCare III Program
Coverage of Pregnant Women

September 13, 2023

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of a planned change to the TennCare program. This change entails enhancements to coverage for low-income pregnant women under TennCare. TennCare is publishing this notice pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare demonstration in order to solicit public input on this planned change.

Description of Planned Program Change

TennCare provides coverage for low-income pregnant women in Tennessee. TennCare's current income threshold for pregnant women is 195 percent of the federal poverty level, meaning that to be eligible for TennCare in this category of coverage, an individual's income must be equivalent to 195 percent of the federal poverty level or lower.

Effective January 1, 2024, TennCare's income threshold for pregnant women will be raised to 250 percent of the federal poverty level.

Individuals enrolled in TennCare as low-income pregnant women receive coverage for the duration of their pregnancy and for 12 months following the end of pregnancy. Benefits covered for pregnant women with incomes below 250 percent of the federal poverty level will be the same as those covered for all other TennCare enrollees. Pregnant women with incomes below 250 percent of the federal poverty level who enroll in TennCare will receive their care through TennCare's managed care service delivery system like all other TennCare enrollees.

Expected Impact on Enrollment and Expenditures

Increasing TennCare's income threshold for pregnant women to 250 percent of the federal poverty level is anticipated to result in an increase in TennCare enrollment of approximately 2,400 people. This change is projected to result in an increase in annual aggregate expenditures of approximately $11 million under the TennCare program.

Evaluation Impact

TennCare does not anticipate modifying its evaluation design based on this planned change. This change is expected to contribute to key goals of the TennCare demonstration already reflected in the demonstration's evaluation design (currently under CMS review). These

include enhancing coverage and benefits available under the TennCare demonstration and supporting improved health outcomes.

Waiver and Expenditure Authorities Requested

TennCare is not requesting any new waiver or expenditure authorities under Section 1115 of the Social Security Act to implement this change.

- Section 1902(a)(10)(A)(ii)(XX) of the Social Security Act allows state Medicaid programs to provide coverage to individuals who:
    - Are under age 65;
    - Are not otherwise eligible for and enrolled in Medicaid; and
    - Have incomes that exceed 133 percent of the federal poverty level but are at or below a threshold established by the state.

Under the terms of the TennCare III demonstration, Tennessee may make changes that add allowable benefits and coverage to the TennCare program without seeking additional approval of a demonstration amendment from the Centers for Medicare & Medicaid Services (CMS).

Public Notice Process

TennCare has taken a variety of steps to ensure that members of the public are notified of this planned change to the TennCare program. These measures include the development and maintenance of this webpage, as well as notices published in newspapers of general circulation in Tennessee communities with 50,000 or more residents.

This planned change was presented by TennCare as a budget request during Tennessee's 2023 legislative session and was approved by the Tennessee General Assembly as part of the state budget through a public legislative process.

In addition, TennCare has disseminated information about this proposed change via its social media accounts (e.g., Facebook, Twitter).

Public Input Process

TennCare is seeking feedback on this planned change. Members of the public are invited to offer comments regarding this change from September 13, 2023, through October 13, 2023.

Members of the public who wish to comment on this planned change may do so through either of the following options:

- Comments may be sent by email to public.notice.tenncare@tn.gov.
- Comments may be mailed to

  Aaron Butler, Director of Policy
  Division of TennCare
  310 Great Circle Road
  Nashville, TN 37243.

Individuals who prefer to make their comments verbally may participate in one of the following public hearings to comment on this planned change:

In-Person Hearing
Location: Room 320.3E of the TennCare Building, 310 Great Circle Road, Nashville, TN.
Date: September 26, 2023
Time: 2:00 p.m. CT

Virtual Hearing
Location: https://tn.webex.com/tn/j.php?MTID=m9b4d9e77e1275b7d3a9ac93b4cfeccf1
Date: September 27, 2023
Time: 10:00 a.m. CT

TennCare always appreciates input. In order to be considered prior to implementation of this change, feedback must be received no later than October 13, 2023. Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.

TennCare Demonstration

A copy of the TennCare Demonstration is available at https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.

TennCare Page on CMS Web Site

As the federal agency with oversight authority over all Medicaid programs, CMS offers its own online resources regarding the TennCare Demonstration. Interested parties may view these materials at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.



TennCare
September 14 ·

A public comment period is currently open for a proposal to raise the income threshold for pregnant women to qualify for TennCare coverage. This public comment period will remain open through October 13, 2023.

For further details, please visit http://TN.gov/.../PregnantWomenComprehensiveNotice.pdf

1

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Attachment U
Pregnancy Eligibility Group Income Threshold





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TennCare
@TennCare

A public comment period is currently open for a proposal to raise the income threshold for pregnant women to qualify for TennCare coverage. This public comment period will remain open through October 13, 2023.

For further details, please visit tn.gov/content/dam/tn....

3:00 PM · Sep 14, 2023 · **104** Views

1

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Jonathan Reeve
@reeve_jona28072

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Jonathan Reeve
@reeve_jona28072



tenncarerep

tenncarerep A public comment period is currently open for a proposal to raise the income threshold for pregnant women to qualify for TennCare coverage. This public comment period will remain open through October 13, 2023.

For further details, please visit our Facebook post.

5w

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SEPTEMBER 14

Add a comment...

Chattanooga Times Free Press

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Matter of: Notice of Change in the TennCare Program

AFFIDAVIT • STATE OF TENNESSEE • HAMILTON COUNTY

Before me personally appeared Samara Swafford, who being duly sworn that she is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

Times Free Press 09/14/23; TimesFreePress.com 09/14/23

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $374.70.

[redacted]

Sworn to and subscribed before me this date:14th day of September, 2023

[redacted]

My Commission Expires 12/14/2026

SHENIQUA HAMBRICK
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES DECEMBER 14, 2026

Chattanooga
Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 37403

Attachment U
Pregnancy Eligibility Group Income Threshold

Notice of Change in the TennCare Program Coverage of Pregnant Women

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TennCare provides coverage for low-income pregnant women in Tennessee. TennCare's current income threshold for pregnant women is 195 percent of the federal poverty level, meaning that to be eligible for TennCare in this category of coverage, an individual's income must be equivalent to 195 percent of the federal poverty level or lower. Effective January 1, 2024, TennCare's income threshold for pregnant women will be raised to 250 percent of the federal poverty level.

Individuals enrolled in TennCare as low-income pregnant women receive coverage for the duration of their pregnancy and for 12 months following the end of pregnancy. Benefits covered for pregnant women with incomes below 250 percent of the federal poverty level will be the same as those covered for all other TennCare enrollees. Pregnant women with incomes below 250 percent of the federal poverty level who enroll in TennCare will receive their care through TennCare's managed care service delivery system like all other TennCare enrollees.

Increasing TennCare's income threshold for pregnant women to 250 percent of the federal poverty level is anticipated to result in an increase in TennCare enrollment of approximately 2,400 people. This change is projected to result in an increase in annual aggregate expenditures of approximately $11 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tncare/documents2/PregnantWomenComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is October 13, 2023.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

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Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

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commercial appeal
PART OF THE USA TODAY NETWORK

# of Affidavits: 2

TENNCARE BUREAU STAT
310 GREAT CIRCLE RD

NASHVILLE, TN 37243-1700

Affidavit of Publication

State of Wisconsin

County of Brown

Personally appeared before me, said legal clerk, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennesse, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached notice was published in the following edition of The Commercial Appeal to-wit :

09/17/23

TENNCARE BUREAU STAT 307573

[redacted] 2023

[redacted]

Notary Public

My commission expires 1-7-25

KATHLEEN ALLEN
Notary Public
State of Wisconsin

Ad Number: 0005825407

Ad Number: 0005825407 Run Dates: 09/17/23

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AFFIDAVIT OF PUBLICATION

0005825205
Newspaper Jackson Sun

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

[redacted] Sales Assistant for the above mentioned newspaper,

hereby certify that the attached advertisement appeared in said newspaper on the following dates:

09/17/23

[redacted]

Subscribed and sworn to before me this 18 day of Sept. 2023

[redacted]

Notary Public exp. 8.25.26

MARIAH VERHAGEN
Notary Public
State of Wisconsin

Affidavits Requested:

0005825205NOTICEOFCHANGEINTHETENNCAREPROG
Re: Notice of Chg

0005825205

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Coverage of Pregnant Women

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THE JOHNSON CITY PRESS
105 East Walnut Street #10
Johnson City, TN 37601

AFFIDAVIT OF PUBLICATION

AD# 1642267

DATES: 9-14-2023

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TennCare provides coverage for low-income pregnant women in Tennes-

State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oath that she is a Representative of The Johnson City Press , a daily newspaper published in Johnson City, in said County and State, and that the advertisement was published in said paper for 1 insertion (s) commencing on 9-14-2023 and ending on 9-14-2023.

[redacted]

Teresa Hicks

Sworn to and Subscribed before me this 9 14 2023

Month Day Year

ROSE LYNN BROOKS
STATE OF TENNESSEE NOTARY PUBLIC
SULLIVAN COUNTY
MY COMMISSION EXPIRES 7-19-2025

[redacted]

Notary Public

My commission expires on July 19, 2025

This legal notice was published online at www.johnsoncitypress.com and www.publicnoticeads.com during the duration of the run dates listed. This publication fully complies with Tennessee Code Annotated 1-3-20

THE JOHNSON CITY PRESS
105 East Walnut Street #10
Johnson City, TN 37601

AFFIDAVIT OF PUBLICATION

AD# 1642267

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Knoxville NEWS SENTINEL
PART OF THE USA TODAY NETWORK

Attn: Jona
STATE OF TN BUREAU O F TENNCARE
310 GREAT CIRCLE ROAD

NASHVILLE, TN 37243

State of Wisconsin)

County of Brown)

Before me, the undersigned, a Notary Public in and for said county,this day personally came said legal clerk first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of

(The Above-Referenced)

of which the annexed is a copy, was published in said paper in the issues dated

09/19/2023

and that the statement of account herewith is correct to the best of his/her

[redacted]

Legal Clerk

Subscribed and sworn to before me this October 4 2023

[redacted]

Notary Public

4-6-27

My commission expires

DENISE ROBERTS
Notary Public
State of Wisconsin

Publication Cost: $192.72
Ad No: 0005825628
Customer No: 1318536

# of Affidavits: 1
This is not an invoice

Attachment U
Pregnancy Eligibility Group Income Threshold

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AFFIDAVIT OF PUBLICATION

0005825310
Newspaper Leaf Chronicle

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

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310 GREAT CIRCLE RD
NASHVILLE, TN
37243

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09/17/23

[redacted]

Subscribed and sworn to before me this 18 day of Sept. 2023.

[redacted]
Notary Public
exp: 8.25.26

MARIAH VERHAGEN
Notary Public
State of Wisconsin

Affidavits Requested:

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Re: NOC

0005825310

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AFFIDAVIT OF PUBLICATION

0005825309
Newspaper The Tennessean

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

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STATE OF TENNESSEE
COUNTY OF OBION

Personally appeared before me, the undersigned Notary Public for Obion County, Tennessee, Jennifer Nicholson, who on oath says he/she is the ~~Publisher~~/Office Manager of the Union City Daily Messenger, a weekly newspaper of general circulation, published at Union City in said county and state, and that the hereto attached

TennCare Notice of Change

Notice was published in said paper for 1 day~~s/weeks~~ as follows

9/20 2023

~~Publisher~~/Office Manager, [redacted]

Publisher's Fee $ 419.98

Subscribed and sworn to me this 20th day of September, 2023.

Notary Public [redacted]
Commission expires July 24, 2024

DONNA L. GIBSON
STATE OF TENNESSEE NOTARY PUBLIC
OBION COUNTY

Legal

tion, homestead, and dower, and all other exemptions which are expressly waived, and subject to any unpaid taxes, if any, the following described property in OBION County, Tennessee, to wit:
PROPERTY LOCATED IN THE COUNTY OF OBION, TENNESSEE:
THE FOLLOWING PROPERTY BEING LOCATED IN CIVIL DISTRICT 6, COUNTY OF OBION, STATE OF TENNESSEE:
BEGINNING AT AN IRON ROD, BEING THE NORTHEAST CORNER OF LOT 5, AND THE SOUTHEAST CORNER AND POINT OF BEGINNING OF THIS HEREIN DESCRIBED TRACT; RUNS THENCE NORTH 87 DEGREES 15 MIN. 42 SEC. WEST, 290.50 FEET TO AN IRON ROD, BEING THE NORTHWEST CORNER OF LOT 5 AND THE SOUTHWEST CORNER OF THIS HEREIN DESCRIBED TRACT; RUNS THENCE NORTH 00 DEGREES 18 MIN. 34 SEC. EAST, 150.00 FEET TO AN IRON ROD BEING THE NORTHWEST CORNER OF THIS HEREIN DESCRIBED TRACT; RUNS THENCE SOUTH 87 DEGREES 15 MIN. 42 SEC. EAST 290.50 FEET TO AN IRON ROD IN THE WEST RIGHT-OF-WAY OF A PROPOSED STREET, BEING THE NORTHEAST CORNER OF THIS HEREIN DESCRIBED TRACT; RUNS THENCE SOUTH 00 DEGREES 18 MIN. 34 SEC. WEST, ALONG THE WEST RIGHT-OF-WAY OF SAID PROPOSED STREET, 150.00 FEET TO THE POINT OF BEGINNING AND CONTAINING 1.00 ACRES, MORE OR LESS.
INCLUDED WITH THE ABOVE DESCRIBED PROPERTY IS A 2010 CHAMPION MOBILE HOME, HAVING VIN # 21000H015156AB. THIS MOBILE HOME WAS DETITLED ON JANUARY 12, 2010.
SEE AFFIDAVIT OF AFFIXATION OF RECORD IN RECORD BOOK 266, PAGE 27, REGISTER'S OFFICE FOR OBION COUNTY, TENNESSEE.
BEING THE SAME PROPERTY CONVEYED TO DYLAN JOSEPH GARCIA BY WARRANTY DEED DATED MAY 1, 2020 AND RECORDED IN RECORD BOOK 255, PAGE 1, REGISTER'S OFFICE FOR OBION COUNTY, TENNESSEE.
THIS IS IMPROVED PROPERTY KNOWN AS 1157 VOLUNTEER DR., TROY, TN 38260.
PARCEL ID: 113 012.04
THE SALE OF THE SUBJECT PROPERTY IS WITHOUT WARRANTY OF ANY KIND, AND IS FURTHER SUBJECT TO THE RIGHT OF ANY TENANT(S) OR OTHER PARTIES OR ENTITIES IN POSSESSION OF THE PROPERTY. ANY REPRESENTATION CONCERNING ANY ASPECT OF THE SUBJECT PROPERTY BY A THIRD PARTY IS NOT THE REPRESENTATION/RESPONSIBILITY OF TRUSTEE(S)/SUBSTITUTE TRUSTEE(S) OR THEIR OFFICE.
THIS SALE IS SUBJECT TO ANY UNPAID TAXES, IF ANY, ANY PRIOR LIENS OR ENCUMBRANCES LEASES, EASEMENTS AND ALL OTHER MATTERS WHICH TAKE PRIORITY OVER THE DEED OF TRUST UNDER WHICH THIS FORECLOSURE SALE IS CONDUCTED, INCLUDING BUT NOT LIMITED TO THE PRIORITY OF ANY FIXTURE FILING.
IF THE U.S. DEPARTMENT OF THE TREASURY/INTERNAL REVENUE SERVICE, THE STATE OF TENNESSEE DEPARTMENT OF REVENUE, OR THE STATE OF TENNESSEE DEPARTMENT OF LABOR AND WORK FORCE DEVELOPMENT ARE LISTED AS INTERESTED PARTIES IN THE ADVERTISEMENT, THEN THE NOTICE OF THIS FORECLOSURE IS BEING GIVEN TO THEM, AND THE SALE WILL BE SUBJECT TO ALL APPLICABLE GOVERNMENTAL ENTITIES RIGHT TO REDEEM THE PROPERTY, ALL AS REQUIRED BY 26 U.S.C. 7425, T.C.A. 67-1-1433, AND 28 U.S.C. 2410 (C). THE NOTICE REQUIREMENTS OF T.C.A. 35-5-101 ET SEQ. HAVE BEEN MET.
THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TRUSTEE/SUBSTITUTE TRUSTEE RESERVES THE RIGHT TO RESCIND THE SALE.
IF YOU PURCHASE A PROPERTY AT THE FORECLOSURE SALE, THE ENTIRE PURCHASE PRICE IS DUE AND PAYABLE AT THE CONCLUSION OF THE AUCTION IN THE FORM OF A CERTIFIED/BANK CHECK MADE PAYABLE TO OR ENDORSED TO LAW OFFICE OF J. PHILLIP JONES. NO PERSONAL CHECKS WILL BE ACCEPTED. TO THIS END, YOU MUST BRING SUFFICIENT FUNDS TO OUTBID THE LENDER AND ANY OTHER BIDDERS. INSUFFICIENT FUNDS WILL NOT BE ACCEPTED. AMOUNTS RECEIVED IN EXCESS OF THE WINNING BID WILL BE REFUNDED TO THE SUCCESSFUL PURCHASER AT THE TIME THE FORECLOSURE DEED IS DELIVERED.
OTHER INTERESTED PARTIES: TENNESSEE HOUSING DEVELOPMENT AGENCY – GREAT CHOICE PLUS PROGRAM
THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.
This is improved property known as 1157 VOLUNTEER DR., TROY, TN 38260.
J. PHILLIP JONES/JESSICA D. BINKLEY SUBSTITUTE TRUSTEE
1800 HAYES STREET
NASHVILLE, TN 37203
(615) 254-4430
www.phillipjoneslaw.com
www.williamsauction.com
F23-0982
9/20/2023,
9/27/2023,
10/4/2023

ESTATE OF
Charles Wesley Byrd,
DECEASED
CASE # 35520
NOTICE TO CREDITORS
NOTICE IS HEREBY GIVEN that on the 11th day of September, 2023 Letters of Administration in respect of the estate of Charles Wesley Byrd who died April 21, 2023 was issued to the undersigned by the Chancery Court of Obion County, Tennessee. All persons, resident and nonresident, having claims, matured or unmatured, against the estate are required to file the same with the clerk of the above named court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1)
(A) Four (4) months from the date of the first publication (or posting, as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1)(A); or
(2) Twelve (12) months from the decedent's date of death. This the 6th day of September, 2023.
/s/ Christopher Shea McPhearson
Administrator
John L. Warner, Jr.
Attorney for the Estate
Emily Hall
Emily Hall, Clerk and Master

ESTATE OF
Elizabeth Kay Sanders,
DECEASED
CASE # 35509
NOTICE TO CREDITORS
NOTICE IS HEREBY GIVEN that on the 1st day of September, 2023 Letters of Administration in respect of the estate of Elizabeth Kay Sanders who died August 15, 2023 was issued to the undersigned by the Chancery Court of Obion County, Tennessee. All persons, resident and nonresident, having claims, matured or unmatured, against the estate are required to file the same with the clerk of the above named court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1) (A) Four (4) months from the date of the first publication (or posting, as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or (B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1)(A); or (2) Twelve (12) months from the decedent's date of death. This the 6th day of September, 2023.
/s/ Joseph David Sanders
Administrator
John L. Warner, Jr.
Attorney for the Estate
Emily Hall
Emily Hall, Clerk and Master
9/13/2023,
9/20/2023

IN THE 27TH JUDICIAL DISTRICT OF THE STATE OF TENNESSEE
CHANCERY COURT OF OBION COUNTY
COREY JONATHAN ESPELAND,
PLAINTIFF,
VS.
KAILA PAIGE ESPELAND,
DEFENDANT.
CIVIL ACTION NO.: 35,517
ORDER OF PUBLICATION
IT APPEARING TO THE CLERK AND MASTER from the original complaint that the Defendant's, Kaila Paige Espeland, whereabouts are unknown.
IT IS THEREFORE ORDERED, ADJUDGED, and DECREED that the above named Defendant serve upon the Honorable David Hamblen, Attorney for Plaintiff, 303 W. Church Street, Union City, TN 38261, an answer to this complaint within thirty (30) days from the last date of publication and also file a copy of said answer with the Clerk and Master of the Chancery Court of Union City, Tennessee, and make defense to said complaint, or the same will be taken as confessed by the Plaintiff, and the cause set for hearing ex parte as to the Defendant.
IT IS FURTHER ORDERED that publication of this notice be made for four consecutive weeks in the Union City Daily Messenger, a daily newspaper published in Obion County, Tennessee.
This the 13th day of September, 2023.
Emily Hall, Clerk and Master
Approved for entry:
David Hamblen, Solicitor

NOTICE OF TRUSTEE'S SALE
WHEREAS, default has occurred in the performance of the covenants, terms, and conditions of a Deed of Trust Note dated August 11, 2010, and the Deed of Trust of even date securing the same, recorded September 1, 2010, in Book No. 57, at Page 55, in Office of the Register of Deeds for Obion County, Tennessee, executed by Shayla Treadwell and Marcus D Treadwell, conveying certain property therein described to Andrew C Rambo as Trustee for Mortgage Electronic Registration Systems, Inc., as beneficiary, as nominee for First Community Mortgage, Inc., its successors and assigns; and the undersigned, Wilson & Associates, P.L.L.C., having been appointed Successor Trustee by Wells Fargo Bank, N.A..
NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable; and that an agent of Wilson & Associates, P.L.L.C., as Successor Trustee, by virtue of the power, duty, and authority vested in and imposed upon said Successor Trustee, by Wells Fargo Bank, N.A., will, on November 14, 2023 on or about 2:00 PM, at the Obion County Courthouse Bill Burnett Circle, Union City, TN 38261, offer for sale certain property hereinafter described to the highest bidder FOR certified funds paid at the conclusion of the sale, or credit bid from a bank or other lending entity pre-approved by the successor trustee. The sale is free from all exemptions, which are expressly waived in the Deed of Trust, said property being real estate situated in Obion County, Tennessee, and being more particularly described as follows:
Beginning at a point at the southeast corner of the Wanda Darlene Johnson Lot in the northerly line of Norwood Drive; thence north 6 degrees 07 minutes east with Johnson's line 220 feet to a point in the northerly line of said Subdivision at Johnson's northeast corner; thence south 83 degrees 53 minutes east with the northerly line of said subdivision 74.29 feet to a point at the northwest corner of the Ralph Adams Lot; thence south 00 degrees and 33 minutes east with the Adams line 221.5 feet to a point in the northerly line of Norwood Drive at his southeast corner; thence north 83 degrees and 53 minutes west with said northerly line 100 feet to the point of beginning. Being identified for tax purposes by the Obion County Assessor's Office as Map 58- B, Group A of Map 58-C, Parcel 16.00. Being subject to restrictions of record in Miscellaneous Book 27-U, page 438, in the Register's Office of Obion County, Tennessee.
ALSO KNOWN AS: 2212 Norwood Drive, Union City, TN 38261-4520
This sale is subject to all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory rights of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. In addition, the following parties may claim an interest in the above- referenced property:
SHAYLA TREADWELL
TENANTS OF MARCUS D TREADWELL
PORTFOLIO RECOVERY ASSOCIATES, LLC
The sale held pursuant to this Notice may be rescinded at the Successor Trustee's option at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. In the event of inclement weather, the trustee hereby announces that the sale will be postponed and that notices of said postponement for inclement weather will be mailed to interested parties of record. W&A No. 356978
DATED September 6, 2023
WILSON & ASSOCIATES, P.L.L.C.,
Successor Trustee
9/13, 9/20, 9/27/2023

Notice of Change in TennCare III Demonstration Amendment 5
The Commissioner of the Tennessee Department of Finance & Administration is providing official notification, pursuant to 59 Fed. Reg. 49249, of intent to file an amendment to the TennCare III demonstration. The amendment, which will be known as "Amendment 5," will be filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland.
Amendment 5 consists of the following three components: (1) expanding access to care for low-income parents and caretaker relatives of dependent children by aligning TennCare's income standard for these individuals with the federal poverty level (i.e., 100 percent of the FPL); (2) covering a supply of 100 disposable diapers per month for children under age 2; and (3) enhancing the home- and community-based services (HCBS) available under the demonstration, with particular emphasis on supporting employment.
The change to TennCare's income standard for parents/caretaker relatives is expected to result in an increase in TennCare enrollment of approximately 8,100 persons. The proposed coverage of diapers for children under age 2 and the proposed changes to TennCare HCBS benefits will not result in any changes to TennCare enrollment. Overall, the changes proposed in this amendment are expected to result in an increase in aggregate annual expenditures of approximately $67.6 million under the TennCare program.
The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment5ComprehensiveNotice.pdf.
Members of the public who wish to comment on TennCare's proposal may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is October 13, 2023.
Copies of this notice will be available in each county office of the Tennessee Department of Health.
We do not treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html
9/20/2023

ADVERTISEMENT
FOR BIDS
Project No. J-7000
The Town of Obion, Tennessee
(Owner)
Separate sealed bids for Obion Sewer Rehab Phase III- 2022 CDBG for the Town of Obion will be received by the Town of Obion at the office of Obion Town Hall,137 East Palestine Avenue, Obion, TN 38240 until 10:00 A.M. C.S.T. Wednesday, October 11, 2023 and then at said office publicly opened and read aloud.
The Information for Bidders, Form of Bid, Form of Contract, Plans, Specifications, and Forms of Bid Bond, Performance and Payment Bond, and other contract documents may be examined at the following:
TLM Associates, Inc. 117 E. Lafayette St. Jackson, TN 38301
West Tennessee Plans Room, 439 Airways Blvd. Jackson, TN 38301
Copies may be obtained at the office of TLM Associates, Inc. located at 117 E. Lafayette St. Jackson, TN 38301 upon payment of $200 for a hard copy set or $50 for a digital copy.
The owner reserves the right to waive any informalities or to reject any or all bids.
Each bidder must deposit with his bid, security in the amount, form and subject to the conditions provided in the Information for Bidders.
All bidders must be licensed General Contractors as required by the Contractor's Licensing Act of 1994 of the General Assembly of the State of Tennessee, and qualified for the type of construction being bid upon.
Attention of bidders is particularly called to the requirements as to conditions of employment to be observed and minimum wage rates to be paid under the contract, Section 3, Segregated Facility, Section 109 and E.O. 11246.
No bidder may withdraw his bid within 60 days after the actual date of the opening thereof.
September 12, 2023
(Date)
Mayor Rodney Underwood
CDBG Manual
Chapter F: Plans and Specifications
Revised
(11/29/2022)
9/20/2023,

Notice of Change in the TennCare Program
Coverage of Pregnant Women
The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare demonstration, of a planned change to the TennCare program. This change entails enhancements to coverage for low-income pregnant women under TennCare. This notice is provided in order to solicit public input on this planned change.
TennCare provides coverage for low-income pregnant women in Tennessee. TennCare's current income threshold for pregnant women is 195 percent of the federal poverty level, meaning that to be eligible for TennCare in this category of coverage, an individual's income must be equivalent to 195 percent of the federal poverty level or lower. Effective January 1, 2024, TennCare's income threshold for pregnant women will be raised to 250 percent of the federal poverty level.
Individuals enrolled in TennCare as low-income pregnant women receive coverage for the duration of their pregnancy and for 12 months following the end of pregnancy. Benefits covered for pregnant women with incomes below 250 percent of the federal poverty level will be the same as those covered for all other TennCare enrollees. Pregnant women with incomes below 250 percent of the federal poverty level who enroll in TennCare will receive their care through TennCare's managed care service delivery system like all other TennCare enrollees.
Increasing TennCare's income threshold for pregnant women to 250 percent of the federal poverty level is

Legal

anticipated to result in an increase in TennCare enrollment of approximately 2,400 people. This change is projected to result in an increase in annual aggregate expenditures of approximately $11 million under the TennCare program.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/PregnantWomenComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is October 13, 2023.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

• A public hearing will be held in person on September 26, 2023, at 2:00 p.m. CT in Room 320.3E of the TennCare Building, 310 Great Circle Road in Nashville.

• A public hearing will be held electronically on September 27, 2023, at 10:00 a.m. CT. Members of the public interested in attending this hearing may access the event at https://tn.webex.com/tn/j.php?MTID=m9b4d9e77e1275b7d3a9ac93b4cfeccf1 on the morning of September 27, 2023.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing. Copies of this notice will be available in each county office of the Tennessee Department of Health. We do not treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html 9/20/2023

Legal

NOTICE

Pursuant of the STATE OF TENNESSEE CHAPTER 31 SELF-STORAGE FACILITY ACT, SUBCHAPTER 66-31-103, the contents of the following leased spaces shall be sold to satisfy the owner's lien: VARIETY SQUARE Storage – 206 E Reelfoot Ave, Union City (Behind Subway). #119, Bridget Richards, #114, Carla Nielson, #13, Robert Jones, #10, Sheila Saeung, #129, Tony Prince. The sale shall take place at 12 noon on Thursday, 5th of October 2023.

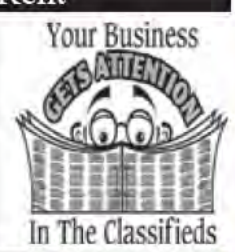
Notice

NOTICE TO FURNISHERS
OF LABOR AND MATERIALS TO:
Pavement Restorations, Inc.
PROJECT NO.:
R4SVAR-M8-021
CONTRACT NO.: CNX057
COUNTY: Obion

The Tennessee Department of Transportation is about to make final settlement with the contractor for construction of the above numbered project. All persons wishing to file claims pursuant to Section 54-5-122, T.C.A. must file same with the Director of Construction, Tennessee Department of Transportation, Suite 700 James K. Polk Bldg., Nashville, Tennessee 37243-0326, on or before 10/27/2023.

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This institution is an opportunity provider and employer.
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Moving Sale
1909 Stonewall
Friday,
September 22nd
7am-1
A lot of misc.!



HUGE YARD SALE
111 N. Mary Jane • Troy
Beside Cut-N-Curl
SATURDAY
SEPTEMBER 23RD
7AM -?
Home and seasonal decor, rugs, bedspreads, pillows, lamps, furniture, toys, appliances, golf clubs, more of everything, lots of new stuff!
Don't miss it!

6 PARTY YARD SALE
FIRST IN A LONG TIME
4807 MT. ZION RD.
UNION CITY
1 MILE FROM CITY LIMITS
FRIDAY 7AM-4
SATURDAY, 7AM-12
Women's boutique clothing, boy's clothing, baby items, Fall and home decor, new handmade tomato baskets, much more!



Auction

PUBLIC AUCTION
SATURDAY • SEPTEMBER 23, 2023 • 10:00 AM
Watch for Signs! Auction will be held rain or shine.
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106 & 108 College Street • Troy, Tennessee 38260
in Obion County
Wonderful Commercial Property
Ronnie & Nancy Johnson - Owners

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Terms: Spacious commercial property sells subject to owners confirmation of bid at 12:00 noon.
10% down balance in 45 days. Note: Lead paint rules apply.
*Buildings offered separately & together.
Additional lot 127 South Main Street offered by itself.*

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SATURDAY, SEPT. 23RD AT 10:00 A.M.
LOCATION: 517 Catlett St., Hickman, KY.
Watch for Signs!!!

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Lisa Wilson, RE Broker Email: Lori@bunchbrothers.com

COMICS

Nancy — By Olivia Jaimes



Adam@Home — By Rob Harrell



CROSSWORD

ACROSS
1 Timetable abbr.
4 Tumbling feat
8 Pipe
12 — & Perrins sauce
13 Deserve
14 Invisible particle
15 Business mag
16 Cousin to an org.
17 Indian garment
18 Game pieces
20 Amass
22 Antlered animal
23 Fiber plant
24 Tennis do-overs
26 Waterproof fabric
30 Part of the hydrosphere
32 — — pinch
33 Opposite of WSW
34 That girl
35 Bond creator — Fleming
37 Strict
39 Deluge
41 Fencer's sword
42 Emotes
43 French article
44 Taiwan's capital
47 Canal setting
50 — Spumante
51 Witticism
53 Set of parts
54 Made as many points
55 Employs
56 Superlative suffix
57 Cooke and Waterston
58 Facilitate
59 Old French coin

DOWN
1 Dismounted
2 "— 911!"
3 Fraudulent dealer
4 Candid
5 Colleen
6 "— Now or Never"
7 Antarctic bird
8 Eats a little of
9 Provo's state
10 Use an auger
11 Eastern potentate
19 "Born Free" lioness
21 Sky-burdened Titan
23 Sleazy places
24 Missing
25 Say what they said
27 Mementos
28 Concerning (2 wds.)
29 Goose of Hawaii
31 Family member
36 Old but valuable
38 New driver, often
40 Rafting challenge
43 Let slip
44 Makes lace
45 '80s supergroup
46 Detail
47 Bake sale items
48 Fermented soybean paste
49 Aleutian island
52 — Today

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Attachment D

Public Comments

American Heart Association.

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Chief Science and Medical Officer
Mariell Jessup, MD, FAHA

Chief Administrative Officer and Corporate Secretary
Larry D. Cannon

April 10, 2023

Aaron Butler, Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE Public Comment in Support
Change to TennCare Program – Postpartum Coverage

Dear Director Butler:

For decades, the American Heart Association has supported legislative proposals that help improve women's heart health. I write this letter today in support of the recent policy change to the TennCare program to increase the income threshold to 250% of the federal poverty level for 12 months of postpartum coverage.

Despite steep declines in global maternal mortality rates over the past two decades, U.S. maternal mortality rates have more than doubled since data collection began in 1987. More than one in three maternal deaths occur in the postpartum period, with cause-specific mortality from heart disease and stroke being highest in the 6 weeks to a year after giving birth.

It is important to recognize that the most dangerous pregnancy-related complications – preeclampsia, blood clots, and heart problems such as cardiomyopathy – may not surface until weeks or months after delivery. Additionally, timely postpartum visits provide an opportunity to address chronic and pregnancy-related health conditions, such as diabetes, high blood pressure, and postpartum depression.

If we increase the income threshold to qualify for postpartum coverage through TennCare, mothers can get the medical care and support they need to ensure longer, healthier lives for new moms and a brighter future for their families.

I hope you will consider this information when finalizing this program change, and please do not hesitate to contact me at 615-419-8955 should you wish to discuss this further.

[redacted]
Sarah Taylor
State Government Relations Director

National Center | 7272 Greenville Avenue | Dallas | Texas | 75231

Division of TennCare

May 1, 2025

Kamia Rathore
State Demonstrations Group
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Notice of Change to Coverage and Benefits under the TennCare Demonstration

Dear Ms. Rathore,

Pursuant to the terms and conditions of the TennCare Demonstration, Tennessee is providing official notice to CMS of our intent to make changes to coverage and benefits available under the Demonstration. These changes add allowable benefits and coverage, as permitted by the Demonstration's STCs.

Specifically, Tennessee intends to add (1) Employment Services and Supports and (2) Enabling Technology to the array of covered HCBS available to individuals enrolled in CHOICES Group 2 and CHOICES Group 3. As you know, these benefits were previously covered for persons enrolled in CHOICES on a temporary basis using funds available to the state under Section 9817 of the American Rescue Plan Act to enhance, expand, and strengthen Medicaid HCBS. According to STC 29.i.vii of the TennCare demonstration, these benefits were covered only through March 31, 2025. This letter serves as notice that Tennessee will again add these services to the array of HCBS available under CHOICES. This change is scheduled for implementation beginning July 1, 2025.

We are pleased to be able to make this enhancement to the benefits available under TennCare. This change will provide enhanced supports and greater flexibility to individuals with disabilities receiving HCBS through CHOICES.

A fuller description of this change is attached to this letter. In addition, we have attached documentation of the state's compliance with the public notice requirements outlined in the Demonstration's STCs.

If you have any questions about this notice or if you need additional information, please contact Aaron Butler at 615.507.6448, or aaron.c.butler@tn.gov.

Sincerely,

[redacted]

Stephen Smith
Director, Division of TennCare

Attachments

Attachment A

Description of Changes to Coverage and Benefits

Description of Changes to Coverage and Benefits

The following provisions related to coverage and benefits under the TennCare Demonstration will become effective on July 1, 2025.

Coverage of Employment Services and Supports for Persons Enrolled in CHOICES Group 2 and CHOICES Group 3. Effective July 1, 2024, TennCare will cover Employment Services and Supports—as defined in Attachment E to the TennCare demonstration and subject to the limitations specified in Attachment E—for persons enrolled in CHOICES Group 2 and persons enrolled in CHOICES Group 3.

Coverage of Enabling Technology for Persons Enrolled in CHOICES Group 2 and CHOICES Group 3. Effective July 1, 2024, TennCare will cover Enabling Technology—as defined in Attachment E to the TennCare demonstration—for persons enrolled in CHOICES Group 2 and persons enrolled in CHOICES Group 3. Coverage of Enabling Technology for persons in CHOICES Groups 2 and 3 will subject to a limit of $5,000 per calendar year.

Attachment B

Description of Public Notice and Input

Description of Public Notice and Input

Effective July 1, 2025, TennCare will cover (1) Employment Services and Supports and (2) Enabling Technology for persons enrolled in CHOICES Group 2 and CHOICES 3. The state has taken a variety of steps to ensure that members of the public have been notified of this planned change and have had an opportunity to provide comments and input. These measures were informed by—and comply with—the STCs of the TennCare Demonstration and 42 CFR § 431.408.

Public Notice

The state held a formal notice and comment period on this proposed change to benefits from March 25, 2025, through April 28, 2025. During this time, a comprehensive description of the planned change was made available for public review and comment on a designated page on the TennCare website. An abbreviated public notice—which included a summary description of the planned change; the locations, dates, and times of two public hearings; and a link to the full public notice on the state's website—was published in the newspapers of widest circulation in Tennessee communities with 50,000 or more residents.

The state held two public hearings to seek public comment on this planned change to TennCare coverage. One hearing took place on April 11, 2025, at 10:00 a.m., Central Time, at the TennCare building, 310 Great Circle Road, Nashville, Tennessee. The other hearing was conducted virtually and took place on April 10, 2025, at 2:00 p.m., Central Time. Members of the public also had the option to submit comments throughout the notice period by mail and email.

In addition, this planned change was presented as a funding request by TennCare during the 2025 session of the Tennessee General Assembly and was approved by the General Assembly as part of the state budget through a public legislative process.

TennCare also disseminated information about this proposed change, including a link to the relevant information on TennCare's website, via its social media accounts (i.e., Facebook, X).

Public Comments

The state did not receive any comments specifically about the proposed change. One individual submitted a question to the state's public comment inbox requesting clarification about the period between the expiration of the Enabling Technology benefit in the STCs on March 31, 2025, and the planned resumption of the Enabling Technology in the new state fiscal year beginning on July 1, 2025. The state responded to the individual's question. The state did not make any changes to its proposal based on this comment.

Attachment C

Documentation of Public Notice

Notice of Change to the TennCare III Program – Coverage of CHOICES Services

Published March 25, 2025

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of a planned change to the TennCare program. This change entails enhancements to the benefits available under the TennCare CHOICES program. TennCare is publishing this notice pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare demonstration in order to solicit public input on this planned change.

Description of Planned Program Change

Within the TennCare demonstration, CHOICES provides an array of home- and community-based services (HCBS) to seniors and adults with physical disabilities.

Effective July 1, 2025, TennCare will cover the following benefits for individuals enrolled in CHOICES Group 2 and CHOICES Group 3.

- Employment Services and Supports, and
- Enabling Technology.

These benefits will be added to the array of HCBS available under CHOICES.

Employment Services and Supports consists of services designed to support individuals with disabilities in obtaining, maintaining, and/or advancing in a job or self-employment, including individual employment support, exploration, benefits counseling, discovery, situational observation and assessment, job development or start-up plan, job development or self-employment start up, job coaching, co-worker supports, career advancement, and integrated employment path services.

Enabling Technology is equipment and/or methodologies that, alone or in combination with associated technologies, provides the means to support an individual's increased independence in their homes, communities, and workplaces.

For more information about Employment Services and Supports and Enabling Technology available through CHOICES, see Attachment E of the TennCare demonstration.

Explanatory Note

In 2022, TennCare began covering Employment Services and Supports and Enabling Technology for individuals enrolled in CHOICES. Coverage of these benefits was supported with temporary funding made available under Section 9817 of the American Rescue Plan Act of 2021. Because the funding to support these benefits was time-limited, coverage of these benefits was time-limited. Under the terms of the TennCare demonstration, Employment Services and Supports and Enabling Technology are not covered benefits for CHOICES members after March 31, 2025.[1]

To allow for ongoing coverage of these services, TennCare has requested legislative appropriations to continue coverage of these services for CHOICES members, beginning in State Fiscal Year 2026. The purpose of this notice is to inform members of the public that Employment Services and Supports and Enabling Technology services will be covered for CHOICES members beginning July 1, 2025, subject to legislative appropriations.

Expected Impact on Enrollment and Expenditures

The addition of Employment Services and Supports and Enabling Technology as covered benefits for CHOICES members on an ongoing basis will not result in the enrollment of additional persons in the TennCare program. Because these services were previously covered under the demonstration using American Rescue Plan Act funding, this change is also not expected to result in material changes to aggregate expenditures under the TennCare demonstration.

Evaluation Impact

TennCare does not anticipate modifying its evaluation design based on this planned change. This change is expected to contribute to key goals of the TennCare demonstration already reflected in the demonstration's evaluation design. These include supporting access to appropriate and cost-effective HCBS.

Waiver and Expenditure Authorities Requested

TennCare is not requesting any new waiver or expenditure authorities under Section 1115 of the Social Security Act to implement this change.

Under the terms of the TennCare III demonstration, TennCare may make changes that add allowable benefits to the program without seeking additional approval of a demonstration amendment from the Centers for Medicare & Medicaid Services (CMS).

[1] The TennCare demonstration states that Employment Services and Supports and Enabling Technology are covered benefits for CHOICES members "until March 31, 2025, or until any subsequent deadline for states to expend funds associated with the enhanced FMAP for HCBS provided for by the American Rescue Plan Act of 2021, whichever is later." The federal government has not established a subsequent deadline for states to expend funds associated with Section 9817 of the American Rescue Plan Act, and in any event Tennessee has exhausted its Section 9817 funding.

Public Notice Process

TennCare has taken a variety of steps to ensure that members of the public are notified of this planned change to the TennCare program. These measures include the development and maintenance of this webpage, as well as notices published in newspapers of general circulation in Tennessee communities with 50,000 or more residents.

In addition, this planned change was presented by TennCare as a budget request during the 2025 legislative session as part of the state budget through a public legislative process.

TennCare has also disseminated information about this proposed change via its social media accounts (e.g., Facebook, X/Twitter).

Public Input Process

TennCare is seeking feedback on this planned change. Members of the public are invited to offer comments regarding this change from March 25, 2025, through April 28, 2025.

Members of the public who wish to comment on this planned change may do so through either of the following options:

- Comments may be sent by email to public.notice.tenncare@tn.gov.
- Comments may be mailed to

  Aaron Butler, Director of Policy
  Division of TennCare
  310 Great Circle Road
  Nashville, TN 37243.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

Virtual Hearing

Location: https://teams.microsoft.com/l/meetup-join/19%3ameeting_ODQ0YzBhZjMtMGQyNy00YzBlLWIxNDUtN2Q0MWEyZTA5OTU2%40thread.v2/0?context=%7b%22Tid%22%3a%22f345bebf-0d71-4337-9281-24b941616c36%22%2c%22Oid%22%3a%22d6fc60e6-dc2c-4e34-8262-ec0bb24d7bdb%22%7d
Date: April 10, 2025
Time: 2:00 p.m. CT

In-Person Hearing

Location: Tennessee Conference Room, TennCare Building, 310 Great Circle Road, Nashville, TN
Date: April 11, 2025
Time: 10:00 a.m. CT

TennCare always appreciates input. In order to be considered prior to implementation of this change, feedback must be received no later than April 28, 2025. Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.

TennCare Demonstration

TennCare's website provides access to a copy of the TennCare demonstration

TennCare Page on CMS Web Site

As the federal agency with oversight authority over all Medicaid programs, CMS offers its own online resources regarding the TennCare demonstration. Interested parties may view these materials at CMS's webpage for state waiver programs.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

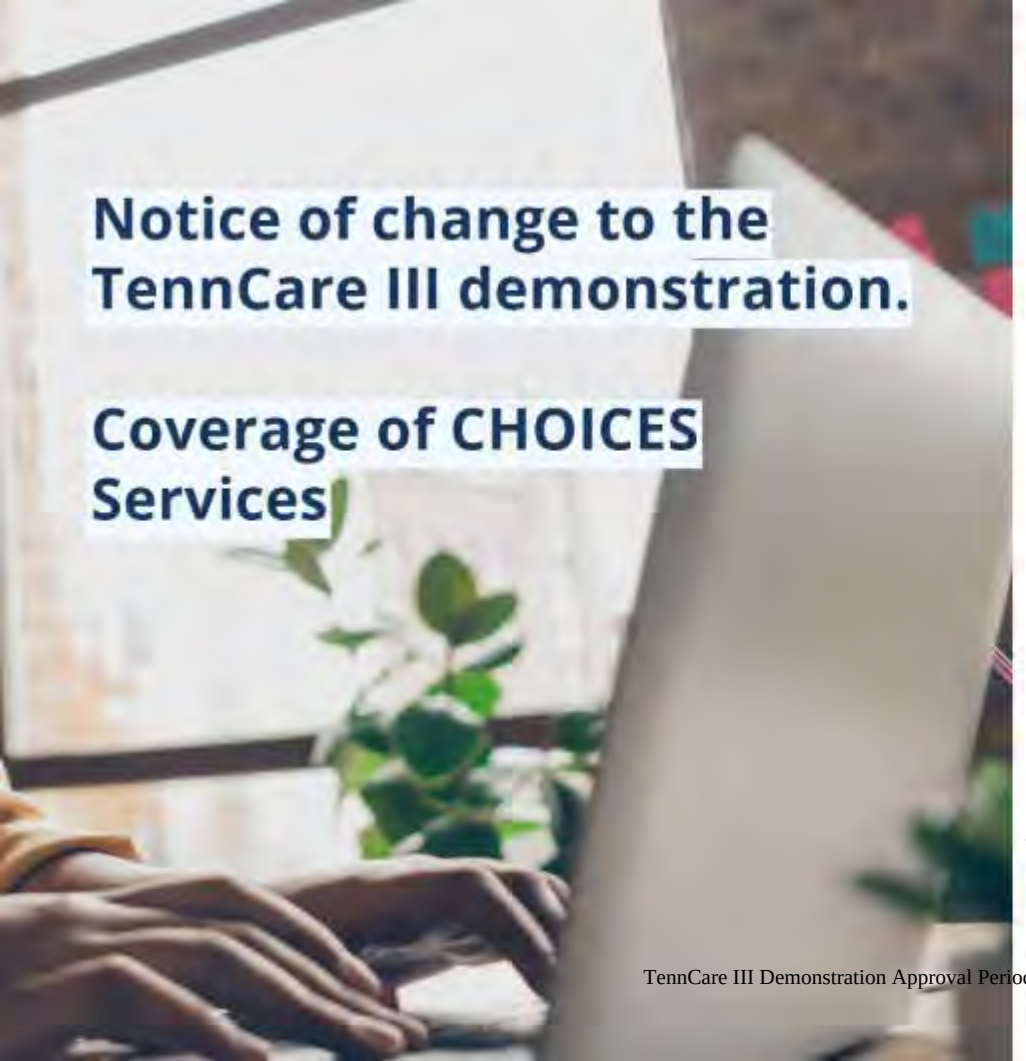
We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Additional information is available on TennCare's Civil Rights Compliance webpage.

TennCare
Published by Caleb Nix
· 16h ·

TennCare plans to introduce two additional benefits to the CHOICES program. Starting on July 1, 2025, in addition to the existing HCBS benefits, Employment Services and Supports, as well as Enabling Technology, will be available for individuals enrolled in CHOICES Group 2 and CHOICES Group 3.

For further details, please visit: http://tn.gov/.../CHOICESBenefitsComprehensiveNotice.pdf





tenncarerep

tenncarerep TennCare plans to introduce two additional benefits to the CHOICES program. Starting on July 1, 2025, in addition to the existing HCBS benefits, Employment Services and Supports, as well as Enabling Technology, will be available for individuals enrolled in CHOICES Group 2 and CHOICES Group 3.

For further details, please visit TN.gov/TennCare and search for "CHOICES Benefits Notice" using the search box.

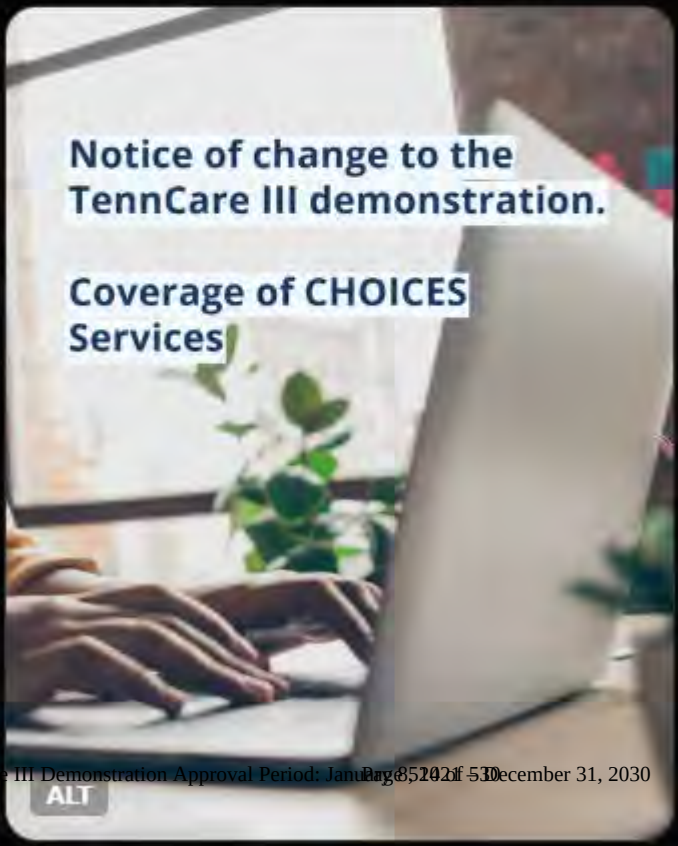
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TennCare plans to introduce two additional benefits to the CHOICES program. Starting on July 1, 2025, in addition to the existing HCBS benefits, Employment Services and Supports, as well as Enabling Technology, will be available for individuals enrolled in CHOICES Group 2 and 3.



tenncarerep 16h

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For further details, please visit: tn.gov/conte...



Chattanooga Times Free Press

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310 GREAT CIRCLE RD
NASHVILLE, TN 37243
Ad number #: 493965
PO #:
Matter of: Notice of Change to the TennCare III Pro

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And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $445.10.

[redacted]

Sworn to and subscribed before me this date:27th day of March, 2025

SHENIQUA HAMBRICK
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES DECEMBER 14, 2026

Sheniqua Hambrick

My Commission Expires 12/14/2026

Chattanooga Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 37403

Notice of Change to the TennCare III Program
Coverage of CHOICES Services

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of a planned change to the TennCare program. This change entails enhancements to the benefits available under the TennCare CHOICES program. TennCare is publishing this notice pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare demonstration in order to solicit public input on this planned change.

Within the TennCare demonstration, CHOICES provides an array of home- and community-based services (HCBS) to seniors and adults with physical disabilities.

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Enabling Technology is equipment and/or methodologies that, alone or in combination with associated technologies, provides the means to support an individual's increased independence in their homes, communities, and workplaces.

The addition of Employment Services and Supports and Enabling Technology as covered benefits for CHOICES members on an ongoing basis will not result in the enrollment of additional persons in the TennCare program. Because these services were previously covered under the demonstration using temporary funding from the American Rescue Plan Act of 2021, this change is also not expected to result in material changes to aggregate expenditures under the TennCare demonstration.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/CHOICESBenefitsComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written

comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is April 28, 2025.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

- A public hearing will be held electronically on April 10, 2025, at 2:00 p.m. CT. Members of the public interested in attending this hearing may access the event on the afternoon of April 10 at https://teams.microsoft.com/l/meetup-join/19%3ameeting_ODQ0YzBhZjMt-MGQyNy00YzBlLWIxNDUtN2Q0MWEyZTA5OTU2%40thread.v2/0?context=%7b%22Tid%22%3a%22f345bebf-0d71-4337-9281-24b941616c36%22%2c%22Oid%22%3a%22d6fc60e6-dc2c-4e34-8262-ec0bb24d7bdb%22%7d.

- A public hearing will be held in person on April 11, 2025, at 10:00 a.m. CT in the Tennessee Conference Room of the TennCare Building, 310 Great Circle Road in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

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PO Box 631340 Cincinnati, OH 45263-1340

AFFIDAVIT OF PUBLICATION

Jonathan Reeve
Tenncare Bureau State Of Tennessee
310 Great Circle RD
Nashville TN 37243-1700

STATE OF WISCONSIN, COUNTY OF BROWN

The Commercial Appeal, a newspaper published in the city of Memphis, Shelby County, State of Tennessee, and personal knowledge of the facts herein state and that the notice hereto annexed was Published in said newspapers in the issue dated and was published on the publicly accessible website:

03/28/2025

and that the fees charged are legal.
Sworn to and subscribed before on 03/28/2025

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Notary, State of WI, County of Brown

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Notice of Change to the TennCare III Program
Coverage of CHOICES Services

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Enabling Technology is equipment and/or methodologies that, alone or in combination with associated technologies, provides the means to support an individual's increased independence in their homes, communities, and workplaces.

The addition of Employment Services and Supports and Enabling Technology as covered benefits for CHOICES members on an ongoing basis will not result in the enrollment of additional persons in the TennCare program. Because these services were previously covered under the demonstration using temporary funding from the American Rescue Plan Act of 2021, this change is also not expected to result in material changes to aggregate expenditures under the TennCare demonstration.

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AFFIDAVIT OF PUBLICATION

Attn: Jonathan Reeve
Bureau Of Tenncare
310 Great Circle Rd
Nashville TN 37243-1700

STATE OF WISCONSIN, COUNTY OF BROWN

The Jackson Sun, a newspaper published in the city of Jackson, Madison County, State of Tennessee, and personal knowledge of the facts herein state and that the notice hereto annexed was Published in said newspapers in the issue dated and was published on the publicly accessible website:

03/30/2025

and that the fees charged are legal.
Sworn to and subscribed before on 03/30/2025

[redacted]

Legal Clerk

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8.25.26

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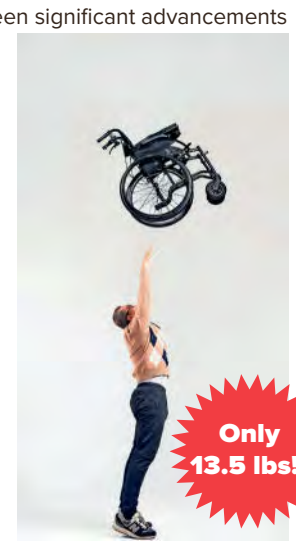


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Publication Dates: 03/29/2025
Ad #: 9210

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on this 31 day of March, 2025.

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My Commission expires: 9.25, 2028.

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Notice of Change to the TennCare III Program

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AFFIDAVIT OF PUBLICATION

Jonathan Reeve
Tenncare Bureau State Of Tennessee
310 Great Circle RD
Nashville TN 37243-1700

STATE OF WISCONSIN, COUNTY OF BROWN

The Knoxville News-Sentinel, a daily newspaper published in the city of Knoxville, Knox County, State of Tennessee, and personal knowledge of the facts herein state and that the notice hereto annexed was Published in said newspapers in the issue dated and was published on the publicly accessible website:

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AFFIDAVIT OF PUBLICATION

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Bureau Of Tenncare
310 Great Circle Rd
Nashville TN 37243-1700

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11166980

Notice of Change to the TennCare III Program Coverage of CHOICES Services

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of a planned change to the TennCare program. This change entails enhancements to the benefits available under the TennCare CHOICES program. TennCare is publishing this notice pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare demonstration in order to solicit public input on this planned change.

Within the TennCare demonstration, CHOICES provides an array of home- and community-based services (HCBS) to seniors and adults with physical disabilities.

Effective July 1, 2025, TennCare will cover the following benefits for individuals enrolled in CHOICES Group 2 and CHOICES Group 3:
- Employment Services and Supports, and
- Enabling Technology.

These benefits will be added to the array of HCBS available under CHOICES.

Employment Services and Supports consists of services designed to support individuals with disabilities in obtaining, maintaining, and/or advancing in a job or self-employment, including individual employment support, exploration, benefits counseling, discovery, situational observation and assessment, job development or start-up plan, job development or self-employment start up, job coaching, co-worker supports, career advancement, and integrated employment path services.

Enabling Technology is equipment and/or methodologies that, alone or in combination with associated technologies, provides the means to support an individual's increased independence in their homes, communities, and workplaces.

The addition of Employment Services and Supports and Enabling Technology as covered benefits for CHOICES members on an ongoing basis will not result in the enrollment of additional persons in the TennCare program. Because these services were previously covered under the demonstration using temporary funding from the American Rescue Plan Act of 2021, this change is also not expected to result in material changes to aggregate expenditures under the TennCare demonstration.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/CHOICESBenefitsComprehensiveNotice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is April 28, 2025.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:
- A public hearing will be held electronically on April 10, 2025, at 2:00 p.m. CT. Members of the public interested in attending this hearing may access the event on the afternoon of April 10 at https://teams.microsoft.com/l/meetup-join/19%3ameeting_ODQ0YzBhZjMtMGQyNy00YzBlLWIxN-DUtN2Q0MWEyZTA5OTU2%40thread.v2/0?context=%7b%22Tid%22%3a%22f345bebf-0d71-4337-9281-24b941616c36%22%2c%22Oid%22%3a%22d6fc60e6-dc2c-4e34-8262-ec0bb24d7bdb%22%7d.
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Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

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AFFIDAVIT OF PUBLICATION

Attn: Jonathan Reeve
Bureau Of Tenncare
310 Great Circle Rd
Nashville TN 37243-1700

STATE OF WISCONSIN, COUNTY OF BROWN

The Tennessean, a newspaper published in the city of Nashville, Davidson County, State of Tennessee, and personal knowledge of the facts herein state and that the notice hereto annexed was Published in said newspapers in the issue dated and was published on the publicly accessible website:

03/30/2025

and that the fees charged are legal.
Sworn to and subscribed before on 03/30/2025

[redacted]

Legal Clerk [redacted]

Notary, State of WI, County of Brown

8·25·26

My commission expires

Publication Cost:	$1921.72	
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All classified ads are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Nashville Tennessean reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Nashville Tennessean shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

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Careers Jobs new beginnings...

Engineering-IT

AllianceBernstein L.P.
seeks AO/Global Analytics Quantitative Analyst in Nashville, TN to help conduct quantitative analysis of investment portfolio data for ad-hoc user requests. Must appear in office 3 dys/wk. WFH permissible 2 dys/wk. Salary at least $73,400. Ref Job code 8372678 and email res to AB-Applications@alliancebernstein.com

Schneider Electric Engineering Services, LLC
seeks a Power System Engineer – II in Franklin, TN. Position eligible for 100% remote work, reporting to company site in Franklin, TN. 30% domestic travel to customer sites for studies, digital relay programming and commissioning, and troubleshooting (expenses to be paid by employer). EOE. To Apply: Visit http://careers.se.com and search Req#87819

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Engineering-IT

Cellular South, Inc. d/b/a C Spire seeks full-time Software Developer II to join its team in Brentwood, TN, the primary area of intended employment.
Periodic travel to HQ in Ridgeland, MS may be required.

JOB DESCRIPTION: Responsible for the design, development and maintenance of highly specialized web-based applications; work with team of Software Developers to solve complex problems and deliver automated, scalable and exceptional user experiences. Additionally, the duties include: develop new programs or modify existing applications based on project requirements, following established standards for the design, coding, and testing of software; work with internal and external customers to validate system testing and conformity with C Spire requirements; assist in unit and integration testing, presenting results, and obtaining agreement and approval; follow change management and implementation procedures; research, propose, and implement solutions to production issues and trouble tickets as assigned; and, prepare program and process documentation.

REQUIREMENTS: Bachelor's degree in Information Systems or Computer Science; strong knowledge of commonly-used concepts, lifecycle methodologies, practices, and procedures within the software development field, especially UNIX and Windows operating systems; software development experience, specifically front-end web-based applications, and the ability to effectively troubleshoot system problems; excellent oral and written communication skills; and, knowledge and working ability in software web-based applications, including Java, Spring Framework, JSON, REST, SOAP, SQL, XML, J2EE, HTML, CSS, JavaScript, and AngularJS.

C Spire is an Equal Opportunity Employer.

TO APPLY: https://www.cspire.com/web/wireless/careers-technical

Slalom's Nashville, TN office has multiple openings for Technology Consultant (various types/levels):
Design and/or customize software for client use with the aim of optimizing operational efficiency. Must be available to work projects at various, unanticipated sites within commuting distance of Slalom's Nashville, TN office. Some telecommuting is permitted.

IT Professionals:
Ent. Lvl to Sen. Lvl. DBAs, Data Anlysts & SW Engineers. are needed for our Nashville, TN Office. May req. traveling. Pls send resume, Cvr Ltr., & Sal. Req. to Neotek Solutions LLC - 4276 Panorama Dr., Dublin, CA, 94568.

Senior Application Developer (Software Developer) needed for HCA IT&S Field Operations located in Nashville, TN.
Engage in analysis, design, and development of mobile, web based, and backend applications. Will utilize Swift, Java Script, GitHub, HTML, Confluence, Web Services, and Azure DevOps. Will write SQL Queries. May work remotely from home anywhere within the continental United States. Must have a bachelor's degree in computer science or engineering and 3 years of experience in the skill sets listed in the job description. Will also accept a master's degree in computer science or engineering and 1 year of experience in the skill sets listed in the job description. Send resumes to: elaine.healy@hcahealthcare.com

Schneider Electric USA, Inc.
seeks a Manufacturing Program Manager in Franklin, TN. Eligible for remote work up to 2 days/wk. Position requires 15% travel (amount can vary dependent on project) to SE sites and suppliers to review production lines, components, and processes (expenses to be paid by employer). EOE. To Apply: Visit http://careers.se.com and search Req#87815

Engineering-IT

Senior Application Engineer (HCA Management Services LP, Nashville, TN
Req: Bach (US/frgn eqv) in CS or rel + 4 yrs app engr exp. Alt will accept Mast (U.S./frgn eqv) in CS or rel + 2 yrs app engr exp. Also Req: strong exp w/GCP Svcs & Hadoop app dsgn & impl; exp in GKE, BQ, Dataflow, Spark Streaming, Java, Python, Scala, SQL, JSON, Avro, Parquet & Kafka; exp w/Bigtable, Cloud SQL, NoSQL/RDBMS db; exp in CI/CD, Git & deployment process; exp in AI/ML & modeling to inc domain exp in ML Techniques, AI, Proc Auto, Robotic Process Auto & NLP; exp deploying Big Data Tech to Prod; und of fund cloud comp concepts, inc hands-on exp w/GCP platform; und of Lambda Dsgn Archs & Real-Time Streaming; strong practical exp in agile app dvlpmt, file sys mgmt & DevOps discipline & practice using short-cycle iterations to deliver cont bus value. Email resume to Elaine.Healy@hcahealthcare.com.

Asurion, LLC
seeks DevOps Engineer 2 in Nashville, TN, provide configuration and build support along incident support within Asurion Global Enterprise. Telecommuting permitted. Apply at https://www.jobpostingtoday.com/Ref #64968.

YAPP USA Automotive Systems, Inc.
seeks the following (work location: Gallatin, TN). Please send cover letter, job code and resume to H. Hao, YAPP USA Automotive Systems, Inc., 300 ABC Blvd., Gallatin, TN 37066.

Quality Manager (QMTENN) responsible for formulating & implementing effective quality control systems for current & future products, as well as improve & perfect their quality control in practice. Req. Bachelor Deg. or equiv. & 3 yrs. exp. Maintenance Engineer (METENN) to assist in plant operations contributing towards improving manufacturing efficiencies by utilizing continuous improvement techniques. Respond to daily equipment trouble and assist in troubleshooting, evaluation & trouble reporting. Req. Bachelor Deg. or equiv. & 1 yr. exp.

Asurion, LLC
seeks Data Scientist in Nashville, TN. Deploy ML solutions in production environment. Telecommuting permitted. Apply @ https://www.jobposting today.com/ Ref #95887.

UBS Business Solutions US LLC has the following positions in Nashville, TN.
Associate Director, Technical Support Specialist to planning and testing the application, configuration and database changes, and installation of upgrades and patches and update production support documentation. Requires B+6yrs. exp. (ref. code(s) 001925). Qualified Applicants apply through SH-ProfRecruitingcc@ubs.com. Please reference 001925. NO CALLS PLEASE. EOE/M/F/D/V. #LI-DNP.

General

Landscape Designer.
Plan and design landscape architectural site plans for land area projects. Employer: Hawkins Partners, Inc. Job location: Nashville, TN. Mail resume to: Will Marth, Hawkins Partners, Inc, 110 S 10th Str., Nashville, TN 37206

Nanny needed for Melinda Noblitt (Nashville, TN).
Care for children in pvt. home. HS diploma or equiv. req. 24 mths exp. as nanny or childcare worker req. Email to: melindahudginsnoblitt@gmail.com

Nashville, TN CLD Group needs a General Laborer
to assist with deliveries, material transport, and inventory. Help manage supplier accounts and coordinate between project teams. Must lift 50 lbs, operate freight equipment, and be fluent in Portuguese for communication with Brazilian clients. Pay: $38,730. Send CV to: robert@thecldgroup.com by 4/30/25

Professional

AMAZON.COM SERVICES LLC, an Amazon.com company -
Nashville, Tennessee. Risk Manager II: Identify, design, develop, implement & execute new & existing processes, policies, goals, & solutions to reduce potential risks. Partial telecommuting permitted; employees will be required to report to office multiple days/week Up to 10% domestic or international travel may be required. Salary Range: $103,917/year to $116,800/year. Job Number: AMZ9081208. Multiple job openings. Apply online: www.amazon.jobs – search by Job Number. EOE.

QA Analyst sought by LG Electronics USA, Inc. in Clarksville, TN
responsible for Field Quality Management & Quality Cost Mngmnt. Reqs: Bachelor's, or foreign equiv in Chem Engnrng, Applied Chem Engnrng, or Manuf. engnrng. Must possess course or work exp w/Organic Polymer Material & Practice; Chem Reaction & Process Engineering; Chem Analytical Design; Heat Material Delivery & Practice; Environmental Engnrng; Organic Chem & Practice; Energy Material Analysis & Lab; & Thermodynamics & Energy. Resumes to LGE USA, Inc., Attn: Sandy Kim 2000 Millbrook Dr. Lincolnshire, IL 60069; Ref Job # 25-TN-3.

Sales Representative: Marca Corona USA LLC;
Mount Pleasant, TN 38474. Resp. for servic'g exist'g accnts in Eastern region o/U.S.: obtain ordrs & establsh new accnts by plan'g & organiz'g daily work schdls. Req.'s: H.S. diploma +36 mos o/employ exp as Sales Rep. Fluency in the Italian langg. Intrntl trvl 2X/yr. Domstic trvl 1 wk/month to various custmrs w/in Eastern region o/U.S. Email CV: c.giubbarelli@gruppoconcorde.it

UBS Bank USA has the following positions in Nashville, TN.
Director, Product Owner, Deposit Products and Platforms to functionally own product vision, strategy and roadmap for deposit product platforms. Requires M+5yrs. exp. or B+7yrs. exp. as an equivalent alternative. Can work remotely. (ref. code(s) 001697). Qualified Applicants apply through SH-ProfRecruitingcc@ubs.com. Please reference 001697. NO CALLS PLEASE. EOE/M/F/D/V. #LI-DNP.

Manager - Consulting: Specialist Resources Global, Inc.
in Franklin, TN: Conduct IT prict mgmt to drive the growth & success of Population Health Mgmt offerings. Travel to unanticipated client locations throughout the US approx 30%, as rqrd. May telecomm from any location w/in the US. Resume to Lcaudillo@emids.com. Job code 57884.0362

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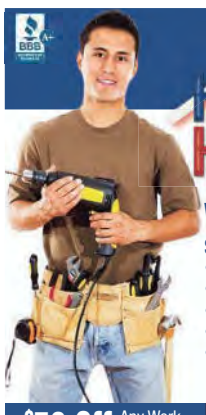
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11166927

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CLASSIFIEDS
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STATE OF TENNESSEE
COUNTY OF OBION

Personally appeared before me, the undersigned Notary Public for Obion County, Tennessee, Tina Isbell, who on oath says he/she is the Classified Advertising Manager of the Union city Daily Messenger, a weekly newspaper of general circulation, published at Union City in said county and state, and that the hereto attached

TN Division of TennCare (Notice of Change to TennCare III Program Coverage of CHOICES Services)

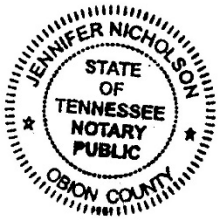
Notice was published in said paper for 1 days/weeks as follows

April 2, 2025.

Classified Advertising Manager [redacted]

Publisher's Fee $378.10 .

Subscribed and sworn to me this 2nd day of April, 2025.



Notary Public [redacted]

My Commission Expires
July 28, 2027

This publication complies with Tennessee Code Annotated § 1-3-120. Public notices can be found at www.nwtntoday.com.

The Messenger

CLASSIFIEDS

Misc. For Sale • Services • Real Estate • Help Wanted

Legal

IN THE 27TH JUDICIAL DISTRICT OF THE STATE OF TENNESSEE CHANCERY COURT OF OBION COUNTY

CIVIL ACTION NO.: 35,990

INGRID RAMIREZ, PLAINTIFF, VS. JORGE ISIDRO CRUZ, DEFENDANT.

ORDER OF PUBLICATION

IT APPEARING TO THE CLERK AND MASTER from the original complaint that the Defendant, Jorge Isidro Cruz, is a non-resident of the State of Tennessee and is believed to be a resident of Guatemala.

IT IS THEREFORE ORDERED, ADJUDGED, and DECREED that the above named Defendant serve upon the Honorable David Hamblen, Attorney for Plaintiff, 303 W. Church Street, Union City, TN 38261, an answer to this complaint within thirty (30) days from the last date of publication and also file a copy of said answer with the Clerk and Master of the Chancery Court of Union City, Tennessee, and make defense to said complaint, or the same will be taken as confessed by the Plaintiff, and the cause set for hearing ex parte as to the Defendant.

IT IS FURTHER ORDERED that publication of this notice be made for four consecutive weeks in the Union City Daily Messenger, a daily newspaper published in Obion County, Tennessee.

This the 4th day of March, 2025.

Emily Hall, Clerk and Master

Approved for entry:
David Hamblen,
Solicitor
03/12/2025, 03/19/2025, 03/26/2025, 04/02/2025

Legal

NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms, and conditions of a Deed of Trust dated August 5, 2002, executed by SAMUEL SHAW, to Jon M. Dickerson as Trustee for REELFOOT BANK, its successors and assigns, recorded on August 8, 2002 in Book 63L, Page 809-822, in Instrument Number: 1031149, in the Register of Deeds Office for Obion County, Tennessee, to which reference is hereby made; and

WHEREAS, SELECT PORTFOLIO SERVICING, INC., hereinafter "Creditor", the party entitled to enforce said security interest, having appointed Robertson, Anschutz, Schneid, Crane & Partners, PLLC, as Substitute Trustee.

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that Robertson, Anschutz, Schneid, Crane & Partners, PLLC, as Substitute Trustee, or its agent, by virtue of the power, duty, and authority vested in and imposed upon said Substitute Trustee, will, on April 15, 2025, at 2:00 PM local time, at the Obion County Courthouse, Bill Burnett Circle, Union City, TN 38261, in Obion County, Tennessee, offer for sale certain property hereinafter described to the highest bidder for cash or certified funds paid at the conclusion of the sale, or credit bid from a bank or other lending entity pre-approved by the Substitute Trustee. The property to be sold is described as follows:

BEING LOT NO. 59 OF THE MAPLEWOOD SUBDIVISION TO THE TOWN OF WOODLAND MILLS, TENNESSEE, PART NO. 2, A PLAT OF WHICH IS OF RECORD IN PLAT BOOK NO.7 PAGE NO. 14, OF THE REGISTER'S OFFICE OF OBION COUNTY, TENNESSEE, AND BEING MORE FULLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE SOUTHWEST CORNER OF LOT NO. 58 AS INDICATED BY AN IRON STAKE, SAME BEING IN THE EAST R.O.W. LINE OF GUM STREET; THENCE NORTH 73 DEGREES 47 MINUTES EAST ALONG THE SOUTH LINE OF LOT NO. 58 FOR 125 FEET TO AN IRON STAKE, SAME BEING THE SOUTHEAST CORNER OF LOT NO. 58 AND NORTHWEST CORNER OF LOT NO. 72, SOUTH 6 DEGREES 13 MINUTES EAST, 112.8 FEET TO A LIGHT POLE, SAME BEING THE SOUTHEAST CORNER OF THE LOT HEREIN DESCRIBED, ALSO THE NORTHEAST CORNER OF LOT NO. 60; THENCE SOUTH 73 DEGREES 47 MINUTES WEST ALONG THE NORTH LINE OF LOT NO. 60, 140 FEET TO AN IRON PIN, SAME BEING THE NORTHWEST CORNER OF LOT NO. 60, SAME ALSO BEING IN THE EAST R.O.W. LINE OF GUM STREET A 50 FOOT R.O.W.; THENCE NORTH 1 DEGREE 13 MINUTES WEST ALONG THE EAST R.O.W. LINE OF GUM STREET 115 FEET TO THE PLACE OF BEGINNING.

BEING THE SAME PROPERTY ACQUIRED BY SAMUEL SHAW BY DEED DATED THIS DATE, OF RECORD IN DEED BOOK 26 - G, PAGE 163-164, IN THE REGISTER'S OFFICE OF OBION COUNTY, TENNESSEE.

Commonly known as: 814 GUM STREET UNION CITY, TN 38261

Parcel number(s): 023K B 019.00 000

In the event of a discrepancy between the legal description, the street address, and/or the parcel number(s), the legal description shall control. The sale is subject to the following: tenant(s)/occupant(s) rights in possession, if any; all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory rights of redemption of any state or federal governmental agency; any prior liens or encumbrances; any priority created by a fixture filing; and any matter that an accurate survey of the property might disclose. Additionally, the following parties might claim an interest in the property: SAMUEL SHAW.

If the United States, the State of Tennessee, or any agency thereof have any liens on the property and are named herein as interested parties, timely notice has been given to them in accordance with applicable law, and the sale will be subject to any applicable rights of redemption held by such entities, as required by 26 U.S.C. § 7425 and/or T.C.A. § 67-1-1433.

The property will be sold AS IS, WHERE IS, WITH ALL FAULTS, and without warranty of any kind, express or implied, as to the condition of the property or any improvements thereon, including but not limited to merchantability or fitness for a particular purpose. The Substitute Trustee makes no covenant of seisin or warranty of title, express or implied, and will only convey the property by Substitute Trustee's Deed. Except as noted above, all right and equity of redemption, statutory or otherwise, homestead, and exemption are expressly waived in the Deed of Trust.

The sale held pursuant to this notice is subject to the express reservation that it may be rescinded by the Substitute Trustee at any time. If the sale is rescinded for any reason, the purchaser shall only be entitled to a refund of funds tendered to purchase the subject property, and shall have no further or other recourse against Creditor, the Substitute Trustee, or their successor(s), assign(s), agent(s), and attorney(s). The right is reserved to adjourn the sale to another day, time, and place certain, without further publication, upon announcement at the time and place for the sale set forth above. Notice of such adjournment will also be mailed to interested parties when required by applicable law.

If you have any questions or concerns, please contact:

Robertson, Anschutz, Schneid, Crane & Partners, PLLC
Attn: TN Foreclosure
13010 Morris Rd, Ste 450
Alpharetta, GA 30004
(423) 498-7400
tnfc@raslg.com

Please reference file number 24-263547 when contacting our office.

Investors website: https://www.rascranesalesinfo.com/

THIS OFFICE MAY BE ACTING AS A DEBT COLLECTOR ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

03/19/2025, 03/26/2025, 04/02/2025

Legal

NOTICE OF PUBLIC MEETING

The Union City Board of Zoning Appeals does hereby give public notice of a special called meeting to be held on Friday, April 11th, 2025, at 8:30 AM in the courtroom of the Municipal Building located at 408 S. Depot St. for the proposal of a variance request at 1508 Julie Street. A copy of the request may be viewed in the office of the Building Inspector during regular business hours. All interested parties are invited and encouraged to attend. It is the policy of the City of Union City, Tennessee not to discriminate on the basis of race, color, national origin, age, sex or disability in its hiring and employment practices, or in admission to, access to, or operation of its programs, services, and activities. If special accommodations are needed in order to fully participate in this meeting, please contact City Hall at least 48 hours in advance.

04/02/2025

Legal

Notice of Change to the TennCare III Program Coverage of CHOICES Services

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of a planned change to the TennCare program. This change entails enhancements to the benefits available under the TennCare CHOICES program. TennCare is publishing this notice pursuant to 42 CFR § 431.408 and the terms and conditions of the TennCare demonstration in order to solicit public input on this planned change.

Within the TennCare demonstration, CHOICES provides an array of home- and community-based services (HCBS) to seniors and adults with physical disabilities.

Effective July 1, 2025, TennCare will cover the following benefits for individuals enrolled in CHOICES Group 2 and CHOICES Group 3:

• Employment Services and Supports, and
• Enabling Technology.

These benefits will be added to the array of HCBS available under CHOICES.

Employment Services and Supports consists of services designed to support individuals with disabilities in obtaining, maintaining, and/or advancing in a job or self-employment, including individual employment support, exploration, benefits counseling, discovery, situational observation and assessment, job development or start-up plan, job development or self-employment start up, job coaching, co-worker supports, career advancement, and integrated employment path services.

Enabling Technology is equipment and/or methodologies that, alone or in combination with associated technologies, provides the means to support an individual's increased independence in their homes, communities, and workplaces.

The addition of Employment Services and Supports and Enabling Technology as covered benefits for CHOICES members on an ongoing basis will not result in the enrollment of additional persons in the TennCare program. Because these services were previously covered under the demonstration using temporary funding from the American Rescue Plan Act of 2021, this change is also not expected to result in material changes to aggregate expenditures under the TennCare demonstration.

The full public notice associated with these changes is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/CHOICES-BenefitsComprehensive-Notice.pdf.

Members of the public who wish to comment on these proposed changes may send written comments by mail to Mr. Aaron Butler, Director of Policy, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is April 28, 2025.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on these planned changes:

• A public hearing will be held electronically on April 10, 2025, at 2:00 p.m. CT. Members of the public interested in attending this hearing may access the event on the afternoon of April 10 at https://teams.microsoft.com/l/meetup-join/19%3ameeting_ODQ0YzBhZjMtMGQyNy00YzBlLWIxNDUtN2Q0MWEyZTA5OTU2%40thread.v2/-0?context=%7b%22Tid%22%3a%22f345bebf-0d71-4337-9281-24b941616c36%22%2c%22Oid%22%3a%22d6fc60e6-dc2c-4e34-8262-ec0bb24d7bdb%22%7d.

• A public hearing will be held in person on April 11, 2025, at 10:00 a.m. CT in the Tennessee Conference Room of the TennCare Building, 310 Great Circle Road in Nashville.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

We do not treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

04/02/2025

Help Wanted

Experienced secretary, with knowledge of computers, needed for office. Send resume to P.O. Box 430, Union City, TN 38261.

For Sake

John Deere X730, 60-inch cut. $5,000; Rayco Stump Grinder, $12,000; Parade Saddle, $500. Call 731-507-0840.

For the Home

Replace your roof with the best looking and longest lasting material steel from Erie Metal Roofs! Three styles and multiple colors available. Guaranteed to last a lifetime! Limited Time Offer up to 50% off installation + Additional 10% off install (for military, health workers & 1st responders.) Call Erie Metal Roofs: 1-855-281-6212 (TnScan)

Olshan Foundation Solutions. Your trusted foundation repair experts since 1933. Foundation repair. Crawl space recovery. Basement waterproofing. Water management and more. Free evaluation. Limited time up to $250 off foundation repair. Call Olshan 1-866-265-5932 (TnScan)

Prepare for power outages today with a Generac Home Standby Generator. Act now to receive a FREE 5-Year warranty with qualifying purchase. Call 1-888-869-5542 today to schedule a free quote. It's not just a generator. It's a power move. (TnScan)

Misc. Media

Get Boost Infinite! Unlimited Talk, Text and Data For Just $25/mo! The Power Of 3 5G Networks, One Low Price! Call Today and Get The Latest iPhone Every Year On Us! 855-454-6457 (TnSCAN)

Services

Available caregiver with great references and good experience. 731-487-2198.

Health/Beauty

Portable Oxygen Concentrator May Be Covered by Medicare! Reclaim independence and mobility with the compact design and long-lasting battery of Inogen One. Free information kit! Call 844-713-6706 (TnScan)

DENTAL INSURANCE from Physicians Mutual Insurance Company. Coverage for 400 plus procedures. Real dental insurance - NOT just a discount plan. Do not wait! Call now! Get your FREE Dental Information Kit with all the details! 1-844-278-8285 www.dental50plus.com/tnpress #6258 (TnScan)

Attention: VIAGRA and CIALIS USERS! A cheaper alternative to high drugstore prices! 50 Pill Special - Only $99! 100% guaranteed. CALL NOW: 1-866-477-7591 (TnScan)

Auctions

GET THE WORD OUT about your next auction! Save Time & $$$. One Call for All. Your ad can appear in this newspaper + 96 other TN newspapers. For more info, contact this newspaper's classified dept. or call Becky Moats 931-624-8916. (TnScan)

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731-885-8004

NURSING HOMES

The Waters of Union City
Rehabilitation & Skilled Nursing Center
We create a supportive home-like environment and our focus is on the individual and their unique needs. We want you to experience the Waters difference and let us help you make the most informed decision possible regarding your healthcare needs. We have a rehab unit with private rooms and we specialize in physical, occupational and speech therapy.
- **Therapy offers services including pain management, VitalStim, wound care, contracture management, stroke rehab, nautilus exercise programs and home evaluations.**
- **Outpatient therapy available.**
- **In house hospice services.**
- **Medicare, Medicaid, Private Pay, Private Insurances accepted.**

1105 S. Sunswept Dr. • Union City, TN
731-885-6400

NURSING HOMES

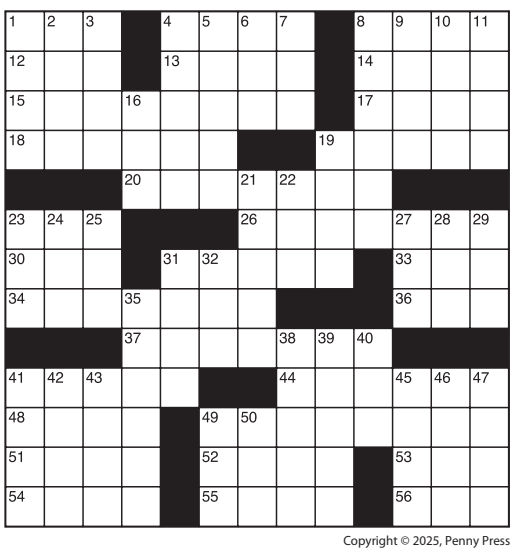
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To List Your Facility In Our Directory, CALL The Messenger Classifieds:
885-0744

CROSSWORD

PUZZLE NO. 284

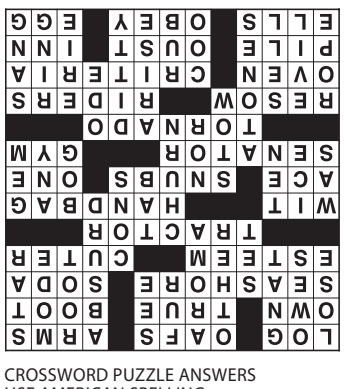


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ACROSS
1. Shipboard diary
4. Louts
8. Upper limbs
12. Have property
13. Not false
14. ____ camp
15. Coast
17. Fountain drink
18. Self-____
19. Prettier
20. Farm vehicle
23. Humor
26. Purse
30. King beater
31. Gives the cold shoulder
33. Individual
34. Lawmaker
36. Fitness center
37. Violent windstorm
41. Plant again
44. Passengers
48. Baking appliance
49. Standards
51. Stack
52. Unseat
53. Traveler's stop
54. Annexes
55. Follow instructions
56. It came first?

DOWN
1. Mislay
2. Has bills
3. Small fly
4. Different
5. Scent
6. Cat's coat
7. Admit as a visitor
8. Ridiculous
9. Applaud
10. Pie a la ____
11. Big name
16. Put in place
19. Negative points
21. Butter maker
22. Dinner check
23. "I ____ a Teenage Werewolf"
24. Skating on thin ____
25. Number of bowling frames
27. Marsh
28. Whichever
29. Sapphire
31. Pack away
32. Neither's mate
35. Does penance
38. Develop
39. Song
40. Work by Keats
41. Line
42. Harmful
43. Persuade
45. Canal from Albany to Buffalo
46. Engagement gift
47. Harmonized
49. Talk fondly
50. Buff

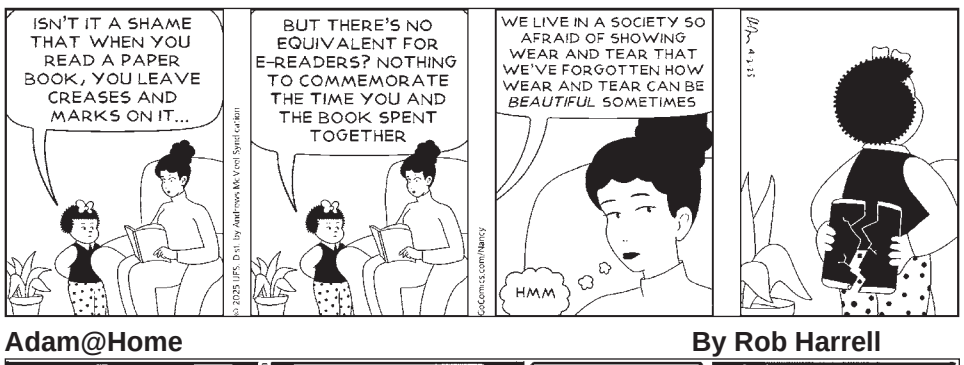
ANSWER TO PUZZLE NO. 284



CROSSWORD PUZZLE ANSWERS
USE AMERICAN SPELLING

COMICS

Nancy — **By Olivia Jaimes**



Adam@Home — **By Rob Harrell**

