Division of TennCare | LTSS

DIVISION OF TENNCARE LONG TERM SERVICES AND SUPPORTS OPERATIONAL PROTOCOL

PROTOCOL TITLE: FAMILY CAREGIVER SUPPORT BENEFIT
EFFECTIVE DATE: NOVEMBER 2, 2021

This protocol sets forth the process and requirements for the increased Family Caregiver Support (FCS) benefits as part of TennCare's Spending Plan for Enhanced Home and Community-Based (HCBS) Federal Medical Assistance Percentage (FMAP) pursuant to the American Rescue Plan Act. This increase is available to eligible individuals enrolled in CHOICES (Groups 2-3), Employment and Community First (ECF) CHOICES (Groups 4-7), and the 1915(c) Waiver programs, as further described below.

A. Background:

Based on stakeholder feedback, TennCare prioritized the provision of additional benefits to support and sustain family caregivers as part of its Enhanced HCBS FMAP Spending Plan. CMS granted Tennessee permission to increase, for a time-limited period, broader access to flexible family caregiver benefits in order to address the additional stresses from impacts of COVID-19 and ensure the sustainability of these supports going forward. This includes the availability of a one-time increase of no more than three thousand dollars ($3,000) available between November 2, 2021 and March 31, 2024, to a TennCare member receiving HCBS in CHOICES (Groups 2 and 3), ECF CHOICES (Groups 4-7), or a Section 1915(c) Waiver, so long as they are either living with family members who routinely provide unpaid support and assistance; or they do not live with family members, but have unpaid family caregivers who routinely provide unpaid support and assistance.

The family caregiver benefit is not available to anyone who is receiving a LTSS residential service, including but not limited to, any level of Community Living Supports or Community Living Supports-Family Model, ACLF, Adult Care Home, Companion Care, Residential Habilitation, or Supported Living.

The one-time increase may be utilized by March 31, 2024 to purchase additional supports and services, specified below, that will further enable the member's independence and/or support and sustain unpaid family caregivers. Such assistance may be provided in addition to existing limitations on these benefits and/or any applicable program expenditure cap.

B. Eligible Services:

The one-time increase may be utilized specifically to purchase the following services in each program:

CHOICES Groups 2 and 3	• Respite; • Adult day services; • Assistive Technology; • Enabling Technology; and • Minor Home Modifications.
ECF CHOICES Groups 4-7	• Respite; • Assistive technology, adaptive; equipment and supplies; • Enabling Technology; and • Minor Home Modifications.
1915(c) Waivers	• Respite; • Specialized Medical Equipment; Supplies, and Assistive Technology; • Enabling Technology; and • Environmental Accessibility Modifications.

For each program, the $3,000 is a one-time increase that may be utilized anytime between the effective date of this amendment and March 31, 2024. 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. This assistance is provided in addition to existing service limitations and without regard for expenditure caps, individual cost neutrality tests, or individual cost limits specified in the approved waiver.

C. Process for Requesting the Benefit:

When an eligible member wishes to receive the FCS benefit, the Coordinator/Case Manager should review with the member the intended usage of the benefit to ensure it meets approved criteria and that the benefit is appropriate for the member.

Once it is confirmed that the member is eligible for the benefit and that the usage of the benefit is appropriate, it should be added to the member's person-centered support plan (PCSP) to go through the subsequent authorization process for the member's specific program.

Before the FCS funds can be utilized, the member must maximize the available benefit to the maximum limit, unless an expenditure cap, individual cost neutrality cap, or individual cost limit would be exceeded. For instance, if the funds were to be utilized for Minor Home Modifications, the $5,000 standard benefit must be used first before the FCS funds are accessed.

D. FCS Benefit Request Workflow:

1. To request the additional benefits, the Coordinator will revise the member's PCSP/Individual Support Plan (ISP) to reflect the amount requested and the intended use of the benefit.
2. The Coordinator will submit the request through either the member's MCO (for CHOICES and ECF CHOICES) or DIDD (for 1915(c) waivers) for review.
3. Upon receipt of the request, the MCO or DIDD, as applicable, will review the request to:
    a. Ensure that the member is either living with family members who routinely provide unpaid support and assistance; or they do not live with family members, but have unpaid family caregivers who routinely provide unpaid support and assistance;
    b. Confirm that the member has fully utilized the resources available under the benefit limit of the service being requested; and
    c. Determine that approval of such service will further enable the member's independence and/or support and sustain unpaid family caregivers.
4. The MCO or DIDD, as applicable, will authorize the requested benefits and pay related claims pursuant to the approved PCSP/ISP.

E. Claims Process

All services will be reimbursed through the claims process with providers billing for the applicable service using the appropriate Healthcare Common Procedure Coding System (HCPCS) and adding the "U6" modifier. Members must use all currently available benefits within the benefit limit before accessing services through the FCS Initiative, unless an expenditure cap, individual cost neutrality cap, or individual cost limit would be exceeded.[1]

F. Tracking and Reporting Requirements:

On a monthly basis, the MCOs and DIDD will report the utilization of each eligible service received through the FCS Benefits. On a template provided by TennCare, the MCOs and DIDD should submit this standalone report by the 20th of each month reflective of the prior month's data (i.e. September data will be due on October 20th).

The reporting requirements will include but are not limited to:

- Member names who requested each FCS Benefit type, stratified by program;
- Number of requests approved and denied per FCS Benefit type, stratified by program.

[1] NOTE: If a member has already reached his individual cost limit, the FCS benefit may be accessed without respect to whether the maximum benefit has already been utilized.

G. References

- Section 9817 of the American Rescue Plan Act of 2021 (ARPA) (Pub. L. 117-2);
- Guidance set forth in SMD# 21-003, issued on May 13, 2021 (https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf);
- Tennessee ARPA FMAP Initial Spending Plan (https://www.tn.gov/content/dam/tn/tenncare/documents/ARPAEnhancedFMAPPlanForHCBS.pdf)