

Aged, Blind and Disabled Manual	Section: CHOICES
Policy Manual Number: 130.005	Chapter: TennCare CHOICES in Long-Term Services and Supports

TENNCARE CHOICES IN LONG-TERM SERVICES AND SUPPORTS

Legal Authority: Social Security Act § 1915(c); 42 CFR 435.217; TennCare 1115 Medicaid Demonstration

1. Overview

The TennCare CHOICES in Long-Term Services and Supports (LTSS) program was established in 2008 with the dual purpose of expanding Home and Community-Based Services (HCBS) in the TennCare program and improving access to HCBS and other long-term care services to those who qualify. The CHOICES program allows the State of Tennessee to integrate all Nursing Facility (NF) care and HCBS into the existing managed care system. Individuals who are eligible for CHOICES are approved under different groups based on the setting in which they receive services and their own Level of Care (LOC) needs.

CHOICES enrollees have their care in the Long-Term Care Facility (LTCF) or HCBS program paid for by TennCare Medicaid. These payments, called LTSS payments, are separate from the regular TennCare Medicaid benefit. An applicant/enrollee must have an approved Pre-Admission Evaluation (PAE) and be enrolled in CHOICES in order to be eligible for LTSS payments.

Within TennCare, the LTSS Unit is responsible for administering the CHOICES program. The LTSS Unit is responsible for determining whether a CHOICES applicant meets the LOC requirements (also known as medical eligibility) and manages enrollment into long-term care programs and database. The Member Services Unit is responsible for determining Medicaid eligibility for a CHOICES applicant. In order to receive CHOICES HCBS, an individual must be eligible in an Institutional Medicaid category or be a Supplemental Security Income (SSI) cash recipient. An individual may not receive CHOICES HCBS without being eligible for Institutional Medicaid.

2. Definitions

- a. Form 2350** An LTCF or HCBS agency reports to TennCare the admission and discharge of its TennCare Medicaid eligible individuals, including SSI cash recipients, in writing via this form titled “Notice Recipient-Patient Was Admitted to or Discharged From Skilled Nursing Facility (SNF) or Intermediate Care”.
- b. Form 2362** A form used to manually update or correct TennCare interChange records regarding patient liability. Form 2362 may only be used when: 1) the begin date of eligibility is so far in the past that the eligibility system cannot create a budget; 2) the enrollee’s only income is SSI; 3) there is a patient liability overcharge; or 4) an individual is in the NF for a short period of time and is eligible for QMB or SSI Cash. The form is sent to the MMIS contractor who keys the update into interChange.

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- c. **Group 1** Individuals who are receiving Medicaid-reimbursed LTSS in a NF. Individuals must be eligible for Medicaid and meet NF Level of Care (LOC) criteria.

- d. **Group 2** Individuals age 65 and older, and adults age 21 and older with physical disabilities, who meet the NF LOC criteria, who are eligible for Medicaid either as SSI cash recipients or in an Institutional category and who need and are receiving HCBS instead of NF care.

- e. **Group 3** SSI cash recipients who do not meet the NF LOC criteria but who, in the absence of HCBS, are “At Risk” for NF care. Group 3 enrollees are eligible for payment of HCBS.

Prior to July 1, 2015, eligibility for Group 3 was not limited to SSI Cash enrollees. Individuals age 65 and older and adults age 21 and older with physical disabilities were also potentially eligible for Group 3. Non-SSI cash enrollees who were enrolled in Group 3 prior to July 1, 2015, were grandfathered in to the program and remain eligible for payment of HCBS so long as they continue to be “At Risk” of nursing home placement.

- f. **Inactive SSI Enrollee** Individuals who have continued to receive Medicaid coverage even though their SSI cash benefits were terminated due to the SSI Cluster Daniels injunction. The injunction was lifted in 2009, and the population now goes through the redetermination process. Inactive SSI enrollees are not eligible for CHOICES. This population is also known as Former SSI Cash Recipients with active SSI Medicaid.

- g. **LTSS Payments** Benefits paid to cover the cost of long-term care in a NF or payments for HCBS for CHOICES-eligible institutionalized individuals.

- h. **Money Follows the Person (MFP)** Demonstration grant obtained by TennCare to help the state improve LTSS for Medicaid recipients who prefer to live in home and community-based settings.

- i. **Personal Needs** Deduction from the institutionalized individual’s patient liability amount to cover personal needs and incidentals. Currently amounts are:
 - i. \$50 per month for individuals in a NF;
 - ii. 300% of the Supplemental Security Income – Federal Benefits Rate (SSI-FBR) for HCBS enrollees and Self-Determination Waiver; and

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iii. 200% of the SSI-FBR for the Arlington and Statewide Waivers.

- j. **Pre-Admission Evaluation (PAE)** Evaluation of an individual’s LOC, or medical need, for LTSS. The PAE is completed by the Area Agency on Aging and Disability (AAAD), discharging hospital, Managed Care Organization (MCO), or NF, and is reviewed by the TennCare LTSS Unit. For Medicaid eligible individuals, the PAE is submitted by the MCO, discharging hospital, or NF.
- k. **Pre-Admission Screening/Resident Review (PASRR)** The process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, a mental illness or an intellectual disability. If so, the PASRR then allows the State to determine whether the individual requires specialized services and is appropriate for NF placement. See TennCare Rule 1200-13-01-.02(114).

3. General Eligibility Criteria

In order to be enrolled in CHOICES, an individual must be determined eligible to receive CHOICES by the LTSS Unit, and be approved for TennCare Medicaid eligibility by the Member Services Unit or be eligible as a SSI cash recipient. It is only once both determinations are made that the individual is enrolled in the programs. An applicant must meet the following conditions to receive CHOICES:

- a. The individual has been determined to need and likely to receive LTCF services for a continuous period of at least 30 days going forward as evidenced by an approved CHOICES Group 1 PAE and actual admission to a NF;
- b. The individual has been admitted to a NF or an Intermediate Care Facility for Individuals with Intellectual Disabilities ICF/IID, and the period of continuous confinement in the institution, combined with the period of time for which a PAE is approved, exceeds 30 days;
- c. The individual is receiving HCBS and has been determined to need HCBS for a continuous period of at least 30 days going forward, as evidenced by an approved CHOICES Group 2 PAE; or
- d. The individual is an SSI cash recipient/enrollee who has entered a NF and does not meet the NF LOC criteria, but in the absence of HCBS is determined to be at risk for NF care. These individuals will have an approved CHOICES Group 3 PAE and will begin receiving CHOICES benefits once they are in the home or community-based setting; and
- e. The individual meets the non-financial and financial eligibility requirements of one of the following TennCare Medicaid categories:
 - i. SSI Cash Recipient;
 - ii. Institutional Medicaid; or
 - iii. SSI-Related (for the month of admission PLUS one month, if necessary to effect closure of the Passalong case and open an Institutional Medicaid case); and

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f. The individual is not in a penalty period for an uncompensated transfer of assets.

NOTE: An individual may be approved for Institutional Medicaid based on 30 days continuous confinement, but they are not enrolled in CHOICES until a PAE is submitted and approved. See Section 7 in this chapter and the *Institutional Medicaid* policy.

4. CHOICES Application Process

a. Overview of Application Process and Materials

The application and enrollment process for CHOICES requires collaboration between TennCare, the local AAAD, LTCFs and the TennCare MCOs.

The AAADs serve as the Single Point of Entry (SPOE) into LTSS for the majority of elderly and physically disabled individuals. When the application process begins with the AAADs, the AAADs submit the Medicaid application to TennCare and complete the LOC assessment. When the application is received without a PAE from another entity (nursing facilities, hospitals, families, individuals or FFM applicants), TennCare refers the HCBS individuals to the AAAD in their area for the LOC assessment only. Enrollment through the AAAD is not mandatory.

TennCare Medicaid MCOs help facilitate enrollment into LTSS for their current members, i.e., individuals who already have TennCare Medicaid eligibility.

To help facilitate the TennCare Medicaid financial eligibility determination and LTSS enrollment processes, the AAAD and MCO staffs use the following TennCare documents:

- i. Checklist of TennCare Requirements for LTSS Enrollment;
- ii. *AAAD-LTSS Facilitated Enrollment Addendum*;
- iii. *MCO-LTSS Eligibility Checklist*; and
- iv. *CHOICES Enrollment Screen* in TennCare Pre-Admission Evaluation System (TPAES).

The TennCare Application for Individuals Needing LTSS, Hospice Care or a Medicare Savings Program (MSP) will be used for all new applicants or enrollees who are required to submit a new application. TennCare Forms 2350 and 2362 will also be used to support enrollment for existing enrollees. Appropriate use of these forms is described in Sections 13 and 14 in this chapter.

b. New Applicants

i. Application

New applicants who apply directly with the state will use the TennCare Application for Individuals Needing LTSS, Hospice Care or a Medicare Savings Program. Applications can

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be mailed or faxed to Tennessee Health Connection (TNHC) and will be processed by the Member Services Waiver Unit.

Individuals who submit an application to the Federally Facilitated Marketplace (FFM) and indicate that they need LTSS will be contacted by TennCare to provide the information necessary to complete the application.

ii. AAAD Responsibilities

1. Serve as facilitated enrollers and assist individuals with completing the TennCare Application for Individuals Needing LTSS, Hospice Care or MSP (TennCare Application);
2. Complete the LOC assessment and submit the PAE to TennCare via TPAES;
3. Submit the TennCare Application via mail or fax;
4. Gather and submit proof of non-financial eligibility criteria;
5. Gather and submit proof of all income and resources, including life insurance; and
6. Provide a signed copy of the *AAAD-LTSS Facilitated Enrollment Addendum*. This document will be used by TennCare along with the application in lieu of an interview.

NOTE: TennCare will be able to verify the following based on available electronic data sources: SSN, Citizenship, SSI eligibility, SSI and SSA income.

iii. TennCare LTSS Responsibilities

1. Verify completed PASRR (if applicable);
2. Determine LOC and approve or deny the PAE;
3. Verify CHOICES enrollment criteria have been met; and
4. Place approved PAEs in the TPAES Member Services county queue. TPAES will auto-generate a *CHOICES Enrollment* form and place the item in the Member Services county queue for those with an approved PAE.

iv. TennCare Member Services Responsibilities

1. Process applications received by TNHC (from AAAD, LTCF, hospital or individual);
2. Contact individuals to request any missing information or verifications, to provide information regarding establishing a Qualifying Income Trust (QIT) when gross income exceeds the Medicaid Income Cap (MIC), or to conduct a resource assessment;
3. Refer HCBS applicants who directly submit an application to TennCare to their local AAAD;
4. Determine Medicaid eligibility in an Institutional Medicaid category;

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- a. Applications for HCBS or Hospice services should be under review within 10 days from the application being assigned to the Member Services; and
 - b. All other LTSS applications must be processed within 45 days of being received by TennCare; and
5. Update TPAES based on Institutional Medicaid eligibility determination.

c. Existing Enrollees

i. MCO Responsibilities

1. Facilitate enrollment for existing TennCare Medicaid enrollees;
2. Verify Medicaid category, whether the enrollee has an authorized representative, the date of the scheduled Medicaid annual review, whether the enrollee is QMB, SLMB or QI eligible and whether he or she is an Inactive SSI Enrollee, using TN Anytime, the 834 file or TNHC contact;
3. Provide proof of all resources for enrollees in the following categories: MAGI Child, Pregnant Woman, Caretaker Relative, Foster Care, Breast and Cervical Cancer, and TennCare Standard.
4. Provide a signed copy of the *MCO-LTSS Eligibility Checklist*. This document is used in lieu of an interview.

A TennCare Application for Individuals Needing LTSS is required if the following occurs:

5. If TennCare Medicaid renewal is due during the month institutional coverage is requested;
6. If the State authorized closure during the month that Institutional Medicaid is requested; or
7. If individual is an Inactive SSI Enrollee and is awaiting redetermination to qualify for Medicaid in another open category (AAADs will submit an application).

ii. TennCare LTSS Responsibilities

1. Verify completed PASRR (if applicable);
2. Determine LOC and approve or deny PAE;
3. Verify that CHOICES enrollment criteria have been met; and
4. Place approved PAEs in the TPAES Member Services county queue.
5. TPAES will auto-generate a *CHOICES Enrollment* form and place the form in the Member Services queue for those with an approved PAE.

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iii. TennCare Member Services Responsibilities

1. Monitor the TPAES queue on a regular basis and retrieve the *CHOICES Enrollment* form and attachments, including the *MCO-LTSS Eligibility Checklist* and any collected verifications from TPAES;
2. Check the *CHOICES Enrollment* form to verify PAE approval and confirm NF admission or that individual will begin receiving HCBS upon approval so that institutional Medicaid eligibility may be determined;
3. Verify eligibility in an existing TennCare Medicaid category;
4. Request an application when the enrollee meets any of the conditions listed in Subsection 4.c.i;
5. Contact enrollee to provide information about a QIT, conduct a resource assessment or collect verifications, if needed; and
6. Process Medicaid eligibility within 10 days from the date the enrollment form and MCO checklist are submitted and available in the queue, and update TPAES accordingly:
 - a. If the individual is determined eligible in an Institutional Medicaid category, terminate Medicaid coverage in the original category and approve the Institutional Medicaid coverage. Update the *CHOICES Enrollment* form in TPAES by entering the Medicaid approval date and Patient Liability amount.
 - b. If the enrollee is determined ineligible for Institutional Medicaid, take the following steps:
 - i. If the enrollee was applying for HCBS, she will retain eligibility in her original TennCare Medicaid category.
 - ii. If the enrollee was applying for NF services, he may remain eligible in his original category for 90 days. If he or she remains in the LTCF for more than 90 days, the non-institutional Medicaid coverage must be terminated.
 - iii. If eligibility is terminated, update the *CHOICES Enrollment* form in TPAES with the TennCare Medicaid denial date and archive the *MCO-LTSS Checklist* and *CHOICES Enrollment* form.

iv. Existing Enrollees in a Medicare Savings Program

Individuals only enrolled in a Medicare Savings Program (QMB, SLMB, QDWI or QI1) who are applying for Institutional Medicaid and CHOICES must submit a TennCare Application for LTSS and work with their local AAAD or NF to apply for CHOICES.

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d. SSI Cash Recipients

i. Overview

SSI Cash recipients who apply for LTSS do not need to file a TennCare application and, in general, will not be moved into an Institutional Medicaid category (see exception for SSI Cash recipients with Other Income). An SSI Cash recipient who applies for LTSS must have the following documents:

1. An approved, unexpired PAE;
2. An *MCO-LTSS Eligibility Checklist (if PAE is submitted by the MCO)*; and
3. A *CHOICES Enrollment Form* via TPAES.

When approving a SSI Cash recipient for LTSS, and at subsequent renewals, TennCare will rely on resource eligibility as determined by SSA and income information in SOLQ as reported to and verified by SSA. A new TennCare application or additional verification of resource and income eligibility is not permitted unless there is reason to believe that the individual has additional income or resources beyond what is known to SSA.

ii. SSI Cash Recipients Applying for HCBS

The MCOs facilitate the application process for SSI Cash recipients applying for HCBS. The MCO will submit a PAE to the TennCare LTSS Unit for review. If the PAE is approved, it is placed in the appropriate TPAES Member Services county queue.

Once an approved, unexpired PAE has been established and the PAE has been placed in the Member Services county queue, Member Services will complete the following:

1. Update the Medicaid Approval Date in TPAES with the PAE approval date; and
2. Enter the Patient Liability field in TPAES (\$0 for HCBS).

At the time of PAE application, the MCO representative will act as a contact with the individual and her family or other authorized representative and will notify them of their obligation to report any changes in income to the SSA and to TennCare within 10 days.

iii. SSI Cash Recipients in Long-Term Care Facilities

When a SSI Cash recipient enters an institution, such as a NF, the SSA reduces the SSI cash benefit. The individual's benefit is typically lowered to \$30 a month.

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v. SSI Cash Recipients with no other income

When a SSI Cash recipient who has no other income (or less than \$50 in other income) enters a LTCF, his SSI cash benefit will be reduced, but he will retain SSI eligibility. SSI Cash recipients in a LTCF do not have a patient liability.

A SSI Cash recipient is eligible for CHOICES when she has the following documents:

1. An approved, unexpired PAE;
2. *MCO-LTSS Eligibility Checklist*; and
3. A *CHOICES Enrollment Form* in TPAES.

Update TPAES by entering the \$0 into the Patient Liability field on the CHOICES Enrollment Screen. The Medicaid Approval Date is the PAE Approval Date.

Send Form 2362 to HP via messenger mail or to, HP, 2362 P.O. Box 1700, Nashville, TN 37202-1700, once the individual has been approved for LTSS in order for the MMIS contractor to enter \$0 Patient Liability into interChange.

Send Form 2350 to the SSA at, 120 Athens Way, Nashville, TN 37228, once the individual has been approved for long-term care in a facility as notification that the individual is in a NF.

vi. SSI Cash Recipients with at least \$50 of other income

SSI Cash recipients who enter an institution, and who have at least \$50 in other income, will lose their SSI cash benefit eligibility at some point in the future. Once the individual's SSI cash benefit terminates, she will also lose her SSI Medicaid. In order to prevent a gap in Medicaid coverage, an Institutional Medicaid case will be approved when the individual is determined eligible for CHOICES. Once the SSA terminates the SSI Cash eligibility, the individual will maintain Medicaid eligibility in the Institutional Medicaid case.

Verify the amount of the SSI Cash recipient's additional income in SOLQ. If the amount is greater than \$50, the Eligibility Specialist (ES) must create an open Institutional Medicaid Aged, Blind or Disabled category, as appropriate, for the individual.

NOTE: TennCare will rely on resource eligibility as determined by SSA and income information in SOLQ as reported to and verified by SSA. A new TennCare application or additional verification of resource and income eligibility is not required, unless there is reason to believe that the individual has additional income or resources beyond what is known to SSA.

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Send Form 2350 to the Social Security Administration at 120 Athens Way, Nashville, TN 37228, once the individual has been approved for long-term care in a facility.

e. Inactive SSI Enrollees

Individuals who are eligible as Inactive SSI Enrollees must have eligibility established in an Institutional Medicaid category before CHOICES, an HCBS waiver, or Program of All-Inclusive Care (PACE) can be approved. Inactive SSI Enrollees must have:

- i.** An approved, unexpired PAE;
- ii.** A completed TennCare Application for Individuals Needing LTSS; and
- iii.** A *CHOICES Enrollment* Form in TPAES.

Inactive SSI Enrollees who are applying for CHOICES will be processed according to the procedures provided in Section 4.c.

5. Institutional Medicaid Eligibility and CHOICES Enrollment Dates

a. Approvals

i. Institutional Medicaid

- 1.** If approved for Institutional Medicaid and CHOICES Group 1 (NF), the Medicaid approval date in TPAES is the latter of the date of application or the date of NF admission;
- 2.** If approved for Institutional Medicaid and CHOICES Group 2 (HCBS), the Medicaid approval date in TPAES is the date the case is approved/authorized in the eligibility determination system; or
- 3.** If enrolled as an SSI Cash recipient and approved for CHOICES Group 3 (At Risk HCBS), the Medicaid approval date in TPAES is the date the case is authorized for HCBS.

NOTE: If an applicant requires a QIT to establish eligibility for Institutional Medicaid, then the approval date is the first day of the month in which the QIT is established, but not before the application date or date of NF admission.

ii. CHOICES/TPAES

Update the *CHOICES Enrollment* form in TPAES by entering the Medicaid approval date used in the eligibility system.

b. Denials

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i. Institutional Medicaid

1. If an applicant is required to submit additional information or verifications and fails to do so within 10 days of receiving notice, the Institutional Medicaid application will be denied.
NOTE: If the applicant provides the missing information or verifications prior to 45 days after the application date, the application will be reviewed.
2. If an applicant is applying for HCBS, and he does not have an approved PAE in TPAES, there should be a referral to the AAAD and the application should be held pending.
3. If an applicant is applying for HCBS and she has a denied PAE in TPAES, contact the AAAD prior to denying the Institutional Medicaid application. If the AAAD intends to appeal the PAE denial, the application must be processed and denied in the eligibility determination system.
4. If an applicant is applying for NF care and he has a denied Group 1 PAE in TPAES, determine whether he can be approved for Institutional Medicaid based on 30 days continuous confinement.

ii. CHOICES/TPAES

Update TPAES with the Institutional Medicaid denial if the applicant fails to submit additional information or verification within 10 days of receiving notice. If the disposition of the case changes prior to 45 days after the application date, i.e. the Institutional Medicaid case is approved, update the enrollment tab in TPAES, and contact the LTSS Unit to review the PAE for enrollment in CHOICES.

6. Institutional Medicaid Approval based on 30 Days Continuous Confinement

An applicant for long-term care in a NF may be determined eligible for Institutional Medicaid based on 30 days continuous confinement. Individuals approved for Institutional Medicaid based on 30 days continuous confinement are not eligible for payment of NF services, but are eligible for TennCare Medicaid benefits. Eligibility will be established in an Institutional Medicaid category based on the special income standard (300% FPL) if:

- a. The applicant has been admitted to a NF and has been continuously in a medical institution (i.e. hospital, NF, ICF, SNF or ICF/IDD) for at least 30 days; and
- b. Has met all financial and non-financial eligibility criteria for Institutional Medicaid.

Individuals approved for Institutional Medicaid based on 30 days continuous confinement may not have an approved, unexpired PAE. If an individual is approved based on 30 days continuous confinement, and then later has an approved, unexpired PAE in TPAES for CHOICES Group 1, she will be eligible and enrolled in CHOICES.

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Eligibility for long-term care in a NF based on 30 days continuous confinement only lasts as long as the individual is institutionalized. If the enrollee is discharged from the NF or other medical institution, his Institutional Medicaid eligibility will be terminated.

Applicants for HCBS cannot be approved for Institutional Medicaid based on 30 days continuous confinement. All HCBS applicants must have an approved, unexpired PAE.

7. Medicare Recipients Requiring Co-Pays or Cross-Over Payments for Skilled Nursing Facility Care (Medicare Cross-Over Payments)

a. Policy Overview

Medicare Part A covers the first 100 days in a SNF, when the Medicare enrollee is in the SNF for the purpose of rehabilitation. Medicare typically pays 100% of the cost for the first 20 days, and 80% of the cost for days 21-100. If the Medicare enrollee is also TennCare Medicaid eligible either in an Institutional Medicaid category or QMB, TennCare will pay the Medicare co-pays, or cross-over payments, for days 21-100 of the SNF stay. An approved PAE is not required to establish Medicare cross-over payments. However, patient liability must be established in the following scenarios (even if it is \$0) to process the cross-over payment:

- i. A partial dual-eligible enrollee (Medicare and QMB benefits) is admitted to a nursing home for a short period of time. The QMB eligibility will cover the SNF Medicare co-payments for days 21-100 (See Scenario 1 below for processing instructions).
- ii. A Medicare recipient (who is not QMB eligible) is admitted to the NF, and is confined in a medical institution for at least 30 days. In this scenario, the individual must apply for Institutional Medicaid and will be approved based on 30 days continuous confinement, if otherwise eligible. The Institutional Medicaid eligibility will cover the SNF Medicare co-payments from the date of eligibility through day 100 (See Scenario 2 below for processing instructions).

NOTE: Medicare may pay for more or less than 100 days of SNF, however, 100 days is the general rule. For the sake of this policy, the Institutional Medicaid eligibility will cover the SNF Medicare co-payment from the date of eligibility through day 100 or the last day of Medicare-approved skilled stay day.

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b. Procedures

i. Scenario 1

1. Individual enrolled in Medicare (Parts A and B) and QMB.
2. No TennCare application has been filed.
3. No PAE is required for Medicare co-payments (cross-over payments).
4. No change in eligibility determination system required.
5. No TPAES update is required (enrollee is not entered in TPAES).
6. Enrollee is not required to meet 30 days continuous confinement.
7. TennCare Member Services will send a completed *Form 2362* to the MMIS contractor to key into interChange to the NF, the enrollee, the enrollee's responsible party within 10 business days of receipt of *Form 2350* from the NF.
8. If the enrollee returns home before the first 100 days of SNF coverage, there is no change to the case.
9. If the enrollee files a TennCare Application for LTSS prior to the expiration of the 100 days, the application will be processed and the enrollee may be approved based on continuous confinement, if otherwise eligible. The individual may also be approved for CHOICES if there is an approved Group 1 PAE.

ii. Scenario 2

1. Individual is enrolled in Medicare, but is not QMB eligible.
2. A TennCare Application for LTSS is filed.
3. There is no PAE in TPAES.
4. TennCare Member Services will pend the application to determine whether the applicant meets 30 days continuous confinement.
5. If otherwise eligible, the applicant will be approved for Institutional Medicaid once 30 days continuous confinement is met.
6. The eligibility determination system must include the enrollee's NF Patient Liability amount.
7. If approved, TennCare will pay the co-pays for days 21-100.
8. If the enrollee remains in the NF beyond the last Medicare-approved skilled stay day, her nursing home costs will not be paid for unless she is approved for CHOICES (approved Group 1 PAE).
9. No additional action is required as long as the enrollee remains confined in the NF.

8. Short Term Stay

A short-term stay is one of 90 or less days. HCBS-eligible enrollees who enter a NF may remain active in their HCBS case for 90 days. An enrollee cannot be moved out of HCBS if the NF stay is anticipated to be short-term and the enrollee plans to return home to receive HCBS.

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Short-term NF stays for individuals approved for HCBS will not be reported to the Member Services LTSS unit, as no change in Medicaid eligibility is required. Member Services Waiver Unit should not receive a *CHOICES Transition* form in TPAES or a 2350 form. Should the Member Services Waiver Unit receive a 2350 form from the NF in error, the person should not be moved out of the HCBS case until receipt of a *CHOICES Transition* form in TPAES indicating the person is no longer in HCBS.

During a 90-day short-term nursing facility stay for a person in HCBS, the community Personal Needs Allowance (PNA) will continue to apply (300% of the SSI-FBR). This is to allow the enrollee to maintain his community residence in order to facilitate transition back home.

If the enrollee remains in the NF beyond 90 days (or such time that it is determined the enrollee needs to remain in the NF beyond 90 days), the MCO will facilitate the member's transition via the CHOICES Transition process.

9. Transitions

When a CHOICES individual moves from one CHOICES Group to another, and the move is not a short-term stay, it is considered a transition. Transitions must be processed in TPAES, the eligibility determination system, and documented in interChange.

a. MCO Responsibility

The MCO will report the transition to TennCare by submitting a CHOICES Transition Request via TPAES.

b. TennCare LTSS Responsibilities

The TennCare LTSS Unit reviews the transition request, and if approved, will transition the individual's CHOICES segment in interChange and approve the Transition PAE in TPAES. If denied, the Transition PAE in TPAES is denied. If the transition request is approved, the request is placed in the Member Services county queue.

c. TennCare Member Services Responsibilities

Process the transition in the eligibility determination system within 3 days of receiving the transition request when the expected transition date is not in the future, and update TPAES. When the expected transition date is in the future, leave the Transition PAE pending until the ACCENT budget month arrives for the expected transition date, update the eligibility determination system, and update TPAES. (NOTE: When the transition occurs in the middle of the month, a decrease in patient liability requires a Form 2362 to adjust for the partial month between eligibility system budget periods.)

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Once the transition has been processed in the eligibility determination system, then Member Services will update TPAES as follows:

- i. Log in to the CHOICES individual’s Transition Request;
- ii. Click on the “Calculate Liability” button at the top of the screen;
- iii. Under the “Standard” section, verify the individual’s information and enter the new Patient Liability amount in the “Patient Liability Amount in NF/HCBS Setting”; and
- iv. Indicate whether the address has been updated in the eligibility determination system in the “Address updated in ACCENT,” field (highlighted in green).

NOTE: It is critical that the, “Address updated in ACCENT,” field is completed; otherwise the case will not be removed from the queue once it is updated.

d. Transition Process for SSI Cash Recipients

When a transition request is received for an SSI Cash recipient, the ES must first check State On-Line Query (SOLQ) to determine whether the enrollee receives only SSI cash benefits or if he or she receives SSI cash benefits PLUS more than \$50 in additional income.

i. SSI Cash Recipient with no other income or other income less than \$50

1. Group 1 (NF) to Group 2 or 3 (HCBS) Transition

When an SSI Cash recipient transitions from Group 1 to Group 2, the ES will process the transition request as follows:

- a. Confirm that the individual does not have an open Medicaid case in the eligibility determination system;
- b. Open the transition request in TPAES and click on “Patient Liability”;
- c. Enter \$0 in the Patient Liability field and “No” in the “Address Updated In ACCENT,” field; and
- d. Click on “OK”.

2. Group 2 or 3 (HCBS) to Group 1 (NF) Transition

When a SSI Cash recipient transitions from Group 2 or 3 to Group 1, the ES will process the transition request as follows:

- a. Confirm that the enrollee does not have an open Medicaid case in the eligibility determination system;
- b. Open the transition request in TPAES and click on “Patient Liability”.
- c. Enter \$0 in the Patient Liability field and “No” in the “Address Updated in ACCENT”, field; and

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ii. SSI Cash Recipients with other income over \$50

1. Group 1 (NF) to Group 2 or 3 (HCBS)

When an SSI Cash recipient who has other income over \$50 transitions from Group 1 to Group 2 or 3, the ES will process the transition request as follows:

- a. Determine whether the enrollee has an open Medicaid case in the eligibility determination system and open SSI Cash coverage in interChange. If there is an open Institutional Medicaid Aged, Blind or Disabled case and open SSI Cash coverage, the ES should close the Institutional Medicaid Disabled case;
- b. Open the transition request in TPAES and click on “Patient Liability”;
- c. Enter \$0 in the Patient Liability field and indicate whether the address was updated in the “Address Updated in ACCENT” field; and
- d. Click on “OK”.

2. Group 2 or 3 (HCBS) to Group 1 (NF)

When an SSI Cash recipient who has other income over \$50 transitions from Group 2 or 3 to Group 1, the SSI Cash benefit will terminate at some point in the future. In order to prevent a gap in the individual’s coverage when the SSI Medicaid terminates, TennCare will authorize Institutional Medicaid Aged, Blind or Disabled, as appropriate, in the eligibility system. Since the individual is already Medicaid eligible, a new TennCare application or additional verification of resource and income eligibility is not required unless there is reason to believe that the individual has additional income or resources beyond what is known to SSA. The transition is processed as follows:

- a. Conduct a TPAES search, under the PAE tab, for the enrollee’s Social Security Number;
- b. Determine which TPAES ID (if several exist) is correct, i.e., the TPAES ID under which the enrollee was initially approved for CHOICES;
- c. Use the MCO checklist that was received at the end of the initial HCBS approval in lieu of a TennCare application to establish the Institutional Medicaid case. The MCO Checklist is found in the PAE tab, under Related Items;
- d. If the MCO Checklist is not available, the ES will use the transition request in lieu of an application; and
- e. Use the date that the transition is processed in the eligibility determination system as the receipt date for the MCO Checklist or Transition Request.

iii. Inactive SSI

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If there is an open Institutional Medicaid Disabled case and open SSI Medicaid in interChange, but the SSI Medicaid is “Inactive SSI Enrollee”, the ES should leave the Medicaid case open in the eligibility determination system and process the transition.

If the enrollee does not have an open Medicaid case, continue to follow the instructions below and mark “No” in the “Address Updated in ACCENT,” field in TPAES.

NOTE: An Inactive SSI individual cannot transition to Group 3.

10. Employment and Community First (ECF) CHOICES

a. Overview

The Employment and Community First (ECF) CHOICES program was established in 2016 to provide managed LTSS for individuals with Intellectual and Developmental Disabilities (I/DD) in a home and community-based setting. This includes individuals with I/DD on the waiting list for Department of Intellectual and Developmental Disabilities (DIDD) waivers, individuals with intellectual disabilities not currently receiving HCBS, and individuals with other developmental disabilities previously ineligible for DIDD waivers. The managed LTSS individuals receive are integrated with the physical and behavioral health benefits coordinated by their MCO. The purpose of the program is to promote and support integrated, competitive employment and independent community living as the first and preferred option for individuals with I/DD.

b. Target Populations

ECF CHOICES provides HCBS to four target populations:

- i. Children under age 21 with I/DD living at home with family who meet the NF LOC;
- ii. Children under age 21 with I/DD living at home with family who do not meet the NF LOC, but who, in the absence of HCBS, are at risk of NF placement;
- iii. Adults age 21 and older with I/DD who meet the NF LOC and need specialized services for I/DD; or
- iv. Adults age 21 and older with I/DD who do not meet the NF LOC, but who, in the absence of HCBS, are at risk of NF placement.

c. General Eligibility Requirements

In order to qualify for ECF CHOICES, an individual must:

- i. Have been assessed and found to have an intellectual disability manifested before eighteen years (18) of age or a developmental disability manifested before twenty-two (22) years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); and

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NOTE: For children five years old or younger a “developmental disability” refers to a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disability if services and supports are not provided.

- ii. Be enrolled in TennCare Medicaid as a SSI recipient or through one of the demonstration groups: ECF CHOICES 217-Like Group or Interim ECF CHOICES At-Risk Group.

d. ECF CHOICES Demonstration Groups

i. ECF CHOICES 217-Like Group

Individuals of all ages with I/DD who meet the NF LOC and meet Institutional Medicaid income and resource standards (income up to 300% of the SSI FBR and no more than \$2000 in resources). Institutional Medicaid post-eligibility and spousal impoverishment rules apply.

ii. Interim ECF CHOICES At-Risk Group

Individuals of all ages with I/DD who meet the NF LOC criteria in place on June 30, 2012 but not the criteria in place on July 1, 2012, who in the absence of HCBS, are at risk of institutionalization, and meet Institutional Medicaid income and resource standards (income up to 300% of the SSI FBR and no more than \$2000 in resources).

New enrollment into the Interim ECF CHOICES At-Risk Group will continue until the ECF Choices At-Risk Group and ECF CHOICES Working Disabled Group are established during phase two of the program’s implementation. Individuals who are already enrolled in the Interim ECF CHOICES At-Risk Group may continue to qualify in the group as long as they continue to meet Institutional Medicaid income and resource standards and the NF LOC criteria in place on June 30, 2012, remain continuously eligible, and are enrolled in the Interim ECF CHOICES At-Risk Group.

e. ECF CHOICES Benefit Groups

The ECF CHOICES benefits individuals receive are based on the benefit group into which they are enrolled. Enrollment depends on the individual’s age, the individual’s I/DD status, her medical and/or functional needs, and her TennCare eligibility group. Individuals are enrolled in one of three benefit groups: Essential Family Supports, Essential Supports for Employment and Independent Living, or Comprehensive Supports for Employment and Community Living.

i. Essential Family Supports (ECF CHOICES Group 4)

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Children under age 21 and adults 21 and older with I/DD living with family caregivers, meet the NF LOC or who, in the absence of HCBS, are at risk of institutionalization, and are eligible for SSI or enrolled in one of the demonstration groups.

ii. Essential Supports for Employment and Community Living (ECF CHOICES Group 5)

Adults 21 or older with I/DD who, in the absence of HCBS, are at risk of institutionalization, and are eligible for SSI or enrolled in the Interim ECF CHOICES At-Risk Group.

iii. Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6)

Adults 21 or older with I/DD who meet the NF LOC, need specialized services for I/DD, and are eligible for SSI or enrolled in the ECF CHOICES 217-Like Group.

An individual may transition from one benefit group to another when their level of care changes and in accordance with eligibility criteria for that benefit group. MCO Care Coordinators review LOC on at least an annual basis. A person may request a reassessment of LOC at any time. For benefit groups requiring a NF LOC (ECF CHOICES Group 6), individuals transitioning from the Statewide or Comprehensive Aggregate Cap waivers, who meet the ICF/IID criteria but not the NF LOC criteria, may be granted an exception.

f. ECF Demonstration Group and ECF CHOICES Enrollment Dates

The effective date for enrollment in an ECF demonstration group is the date the case is approved/authorized in the eligibility determination system. The effective date for enrollment in ECF CHOICES is the date the applicant is eligible for and will begin receiving LTSS.

g. Program Administration

TennCare LTSS electronically manages and maintains ECF CHOICES referrals through a statewide referral list. Referral sources include the waiting lists for the current DIDD waivers, local school districts, advocacy groups, medical/clinical professionals that serve individuals with intellectual and developmental disabilities, and online referral forms submitted to TennCare by interested individuals. TennCare LTSS screens potential applicants, refers those likely to qualify for the program to their MCO or DIDD for intake, determines level of care, and manages ECF CHOICES enrollment.

TennCare member services processes applications received for ECF CHOICES, honors applicant MCO selection and refers ECF CHOICES applicants who directly submit an application to TennCare to their regional DIDD.

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The DIDD regional offices assist UnitedHealthcare Community Plan members and individuals who are not enrolled in Medicaid with completing and submitting the online referral form. DIDD is also responsible for performing intake processes and facilitating enrollment, which includes conducting assessments necessary to determine level of care, submitting the PAE application and supporting documentation, providing enrollment counseling and facilitating MCO selection, and submitting the Medicaid application and supporting documentation for persons not already Medicaid eligible.

MCOs assist their current members in applying for the program. This includes assisting members with completing and submitting the online referral form, performing intake processes and facilitating enrollment. After members are enrolled in ECF CHOICES, MCOs are responsible for comprehensive needs assessment and person-centered planning processes and care coordination and support. This includes the development and implementation of a comprehensive, individualized person-centered plan of care for enrollees, encompassing individually identified employment, community living and health and wellness goals.

Employment and Community First CHOICES is managed through the MCOs Amerigroup, BlueCare, and UHC. TennCare Select members will need to select a new MCO to enroll in Employment and Community First CHOICES.

All new HCBS enrollment for individuals with I/DD will be directed to ECF CHOICES. No new persons will be enrolled in the DIDD waivers except an individual transitioning out of DCS custody or an individual identified by the state as a former member of the certified class in *United States vs. State of Tennessee, et al. (Arlington Developmental Center)*, an individual identified by the state as a member of the certified class in *United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center)*, or a person discharged from a State Developmental Center (Clover Bottom or Greene Valley) or the Harold Jordan Center following a stay of at least 90 days. Those currently receiving HCBS under the DIDD waivers will continue to receive HCBS under the existing waivers, but may transition to ECF CHOICES.

11. Other Long-Term Services and Supports Programs

PACE and DIDD HCBS Waivers are not part of the CHOICES program but provide similar services to the eligible populations. More information about PACE and the DIDD Waivers is available at <https://www.tn.gov/tenncare/long-term-services-supports.html>.

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a. PACE

PACE is a community-based health and social services program whose purpose is to serve the frail elderly residents of Hamilton County. Participants must:

- i.** Be age 55 or older;
- ii.** Meet criteria for Level 1 nursing home care; and
- iii.** Meet financial criteria.

The PACE program also provides an adult day care center and covers all medical needs of the individual including, but not limited to, hospitalization and nursing home coverage.

b. DIDD Waivers

The DIDD Waivers provide LTSS for individuals with I/DD through one of two environments:

- i.** ICF/IIDs
- ii.** HCBS

Although the DIDD waivers are not a part of the CHOICES program, individuals eligible for a DIDD waiver must meet the non-financial and financial eligibility requirements of an Institutionalized Medicaid category or receive SSI Cash benefits. Medical eligibility (i.e., LOC) is determined by TennCare’s LTSS Unit and processed in TPAES.

The DIDD serves as the Operational Administrative Agency for the DIDD waivers which are administered under the supervision of TennCare.

c. Statewide ID Waiver

The Statewide ID waiver provides services to Tennessee children with developmental delays and adults and children with intellectual disability who meet the ICF/IID LOC criteria.

d. Comprehensive Aggregate Cap Waiver

The Comprehensive Aggregate Cap (CAC) Waiver, formerly known as the Arlington Waiver, provides services to individuals with intellectual disabilities who are former class members in the *United States vs. The State of Tennessee, et al.* (Arlington Developmental Center), current class members in the *United States vs. the State of Tennessee, et al.* (Clover Bottom Developmental Center), and individuals transitioned from the Statewide Waiver upon its renewal on January 1, 2015. Individuals eligible under the CAC Waiver have been institutionalized in a public institution, are part of a certified class because they were determined to be at risk of placement in a public institution, or require a LOC that would otherwise require placement in an ICF/IID, if they were not receiving services provided under the waiver.

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e. Self-Determination Waiver

The Self-Determination Waiver provides community-based services to individuals with developmental disabilities who would otherwise require the LOC provided in an ICF/IID.

To enroll in this waiver program, an individual must:

- i.** Be a Tennessee resident;
- ii.** Be financially eligible for TennCare Medicaid (Institutional Medicaid or SSI Cash);
- iii.** Meet TennCare Medicaid criteria for payment of institutional ICF/IID care; and
- iv.** Have an adequate support system to assure health and safety while receiving services in a home and community based setting.

12. Form 2350

Form 2350, “Notice Recipient-Patient was Admitted to or Discharged from Skilled Nursing Home Care or Intermediate Care”, is used by a LTCF or HCBS agency to notify TennCare of an applicant or enrollee’s status.

a. Form 2350 contains the following information:

- i.** The name, Social Security number and date of birth for the patient;
- ii.** The date of admission to the facility, i.e. the first date the facility will accept TennCare Medicaid reimbursement for the individual’s care;
- iii.** The name and address of the responsible party;
- iv.** The amount and source of the individual’s income;
- v.** The PAE effective date for CHOICES applicants/enrollees, if known.
NOTE: The PAE effective date must be included on HCBS cases to verify enrollment in the waiver program;
- vi.** The name and address of the medical facility from which the individual was discharged, if applicable; and
- vii.** The LOC to which the individual is admitted.

b. Form 2350 reports the LOC, the individual’s forwarding address and the date the individual is officially discharged from the facility due to one of the following:

- i.** Discharged to home;
- ii.** Transferred to another facility;
- iii.** Expiration of the bed-hold;
- iv.** Therapeutic leave expiration; or
- v.** The individual’s death including the last day of care and the date of death.

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If a Form 2350 is received from a LTCF or HCBS agency regarding an individual who is not currently eligible or who has not filed an application, the ES will contact the facility or agency to determine whether an application should be filed. If the individual is in need of TennCare Medicaid and wishes to apply, the ES will work with the individual, the facility, or the agency to ensure that an application is filed.

13. Form 2362

a. Permissible Use of Form 2362

Form 2362, “Notice of Disposition or Change” (for Skilled Nursing Care and ICFs) is used to notify the individual confined to long-term care and his authorized representative or responsible party of a change in patient liability. The form is completed manually and there are limitations on when it can be used.

Form 2362 may only be submitted to HP Operations in any of the following four situations:

- i.** When the begin date of eligibility is so far in the past that the eligibility system cannot create a budget;
- ii.** When the enrollee’s only income is SSI;
- iii.** When there is a patient liability overcharge; and
- iv.** When an individual is in the NF for a short period of time and is eligible for QMB or SSI Buy-In. The ES ensures patient liability is \$0 on the 2362.

Upon receipt, HP Operations will key the patient liability noted on the 2362 into interChange.

b. Recipients

The following individuals or entities may receive a copy of Form 2362:

- i.** The enrollee;
- ii.** The authorized representative, if applicable;
- iii.** The LTCF or NF;
- iv.** HP Operations; and
- v.** The DIDD Fiscal Services and Office of Community Services (only for HCBS cases processed by DIDD caseworkers).

c. Patient Liability Changes

Monthly deadlines for submitted patient liability changes on active cases have been established. Any increase in the amount of the patient liability requires enrollee notification of 10 days prior to the effective date. A decrease in the amount of the patient’s liability does not require notification 10 days prior to the effective date though an explanation of the reduction is required.

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Any change in the amount of patient liability with an effective date in a prior or current month is prohibited UNLESS:

- i. To recalculate patient liability for the last month of institutionalization due to death or discharge and there are additional Item D's to be considered; or
- ii. A correction is being made in a patient liability overcharge due to an agency error (corrections may be made up to the past 24 months).

An agency error means a mistake by the ES resulting in an overstated liability or overdue eligibility review. An agency error does not include an error made that is the result of the failure of the enrollee, the authorized representative or the LTSS provider to report changes within 10 days of their occurrence, or any error that is not directly attributable to the caseworker such as Item Ds which cannot be deducted in full for the last month of institutionalization because the expense exceeds income.

A patient liability overcharge that occurred in a prior month can be adjusted in a future month(s) IF the overcharge was the result of an agency error or administrative procedures. The correction may also be adjusted retroactively, if necessary. A patient liability overcharge results when the enrollee pays more toward the cost of his care than he should have, or when the individual's Item D deductions are greater than his countable income.

Adjust the overstated liability as soon as possible after it is discovered. Confine the adjustment to one month if at all possible even though it may reduce the patient liability to zero. An adjustment may continue more than one month if necessary to fully reimburse the enrollee. Explicitly label the Form 2362 as a "Correction" for retroactive corrections or enter as a patient liability overcharge on the appropriate budget screen. Immediately terminate the adjustment effective the month following the adjustment month (or later, if necessary). Notice must be given at least 10 days before the effective date of the increase in patient liability.

All Notice of Disposition or Change Forms (Form 2362) are now processed by HP. They should be forwarded through messenger mail to H.P. at 310 Great Circle Road or mailed to the address below:

H.P. 2362
P.O. Box 1700
Nashville, TN 37202-1700

If it is not possible to fully adjust an overstated liability for some reason, e.g. the individual's financial situation changes or the case is closed, there is no mechanism for the individual's recoupment of any overstated patient liability other than through retroactive correction of the overcharge using Form 2362. The Form 2362 must clearly indicate "Correction" at the upper

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portion of the form and may contain corrections for up to the previous 24 months from the current processing month.

14. Facility Types

TennCare Medicaid LTSS payments are available to eligible individuals receiving LTSS in the following medical institutions:

a. State Developmental Centers for the Developmentally Disabled, which include:

- i. Certified Intermediate Care Facility for People with Developmental Disability wards for patients of any age; and
- ii. Certified Level II nursing wards for patients of any age. Patients in non-certified wards in Level II care are not eligible for TennCare Medicaid, except when transferred to a Title XIX (TennCare Medicaid approved) facility.

b. State Mental Health Hospitals and Private Certified Mental Health Hospitals

State Mental Health Hospitals and Private Certified Mental Health Hospitals include general hospital wards for patients age 65 and older and certified Level I and Level II wards for patients age 65 and older.

Patients in non-certified wards and all patients under age 65 are not eligible for TennCare Medicaid in psychiatric facilities with the following three exceptions:

- i. A patient who was already an active TennCare Medicaid recipient when admitted to the psychiatric facility will be eligible the month of admission (no LTSS payment will be authorized). Coverage cannot extend beyond the month of admission or the earliest month action can be taken to close the case.
- ii. Ineligible patients who are transferred to a Title XIX facility located off the hospital grounds may attain eligibility during their absence from the facility.
- iii. Patients under age 21 may be eligible for TennCare Medicaid if they are receiving active in-patient treatment in an accredited psychiatric hospital. These cases are not defined as long-term institutional cases, as no LTSS payment is made.

c. Licensed Public and Private Nursing Homes, which include:

- i. Level II, ICF, for patients of any age;
- ii. Level II, SNF, for patients of any age; and
- iii. Tuberculosis Care Units for patients age 65 and older.

Tennessee does not have any chest disease/tuberculosis hospitals or care units. Care is limited to TN residents at least age 65 whose out-of-state care has been approved by TennCare.

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Residents of unlicensed nursing homes or custodial homes are not considered to be receiving medical care and therefore do not meet the medical institutionalization technical requirement. These individuals are not eligible for TennCare Medicaid in an institutional category and are not eligible for LTSS payments.

d. Certified Institutions

LTCFs are certified by TennCare and have a TennCare Medicaid per diem rate established by the State Comptroller’s Office. A list of certified facilities and their rates are furnished by the Comptroller’s office. A list is also available at the Department of Health’s website at: <https://www.tn.gov/health>.

If an ES receives a request for TennCare Medicaid reimbursement from a facility not included on the list, contact the Member Services Eligibility Policy Unit for information regarding the facility’s certification status.

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Document Title	CHOICES				
First Published	07.01.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
07.01.2016	11.	Employment and Community First (ECF) CHOICES	17 - 20	Policy Change	AJ
07.01.2016	12.	Other Long-Term Services and Supports Programs- PACE	21	Policy Clarification	AK
12.01.2016	3.	General Eligibility Criteria	3	Policy Clarification	RH
03.18.2019	10.b-c.; 10.g.; 14.b.	Target Populations; General Eligibility Requirements; Program Administration; State Mental Health Hospitals and Private Certified Mental Health Hospitals	17-20; 25	Non-Substantive Change	AJ