



## PROPOSED CHANGES TO TENNCARE'S MEDICAL NECESSITY RULE

### 1) Why is TennCare proposing rule changes regarding private duty nursing?

TennCare is proposing a rule change to maintain consistency for members in the number of hours of private duty nursing they receive and to bring transparency to the process as requested by TennCare stakeholders and families.

Private duty nursing is an optional benefit that TennCare has chosen to provide to adults needing a certain high-level of care. Per state law, TennCare must provide the least costly care. For private duty nursing, TennCare compares the cost of care in an institutional setting to the cost of hiring a private nurse to determine how much nursing care the member can receive under this law. With the rapidly increasing cost of nursing care, TennCare seeks to lock in the current nursing rates to help members and reduce fluctuations in care.

Stakeholders and members have requested transparency around the process of determining care settings and covered benefits. This clarifying rule will not change the criteria TennCare uses for determining the type and level of care a member needs, but it will allow members to have clarity, reliability, and stability in private duty nursing.

### 2) What is medical necessity?

Under state law, TennCare may only pay for services that are within the scope of the program's benefits and determined by TennCare to be medically necessary. T.C.A. 71-5-144. This also means that TennCare members are only entitled to receive medically necessary items that are within the rules of the TennCare program.

To be medically necessary, a covered service:

- (a) must be recommended by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member;
- (b) must be required in order to diagnose or treat a member's medical condition;
- (c) must be safe and effective;
- (d) must not be experimental or investigational; and
- (e) must be the least costly alternative course of diagnosis or treatment that is adequate for the member's medical condition.

Medical necessity criteria have been state law since 2004 and that is not being changed with the proposed rules. The proposed rule changes provide clarity on how medical necessity's least costly requirement is applied to private duty nursing.



### 3) How does TennCare determine whether PDN is medically necessary?

TennCare will apply the medical necessity criteria (or “prongs”) above to determine if a covered benefit is medically necessary. This includes ensuring the amount of PDN requested is safe and effective and that it is the least costly option that is adequate for the member’s medical condition.

Where there are less costly alternatives, including other settings, more costly options are not medically necessary. This is also known as “prong (e)” of medical necessity and is not applied to children under age 21 receiving PDN. As a result, TennCare is required by state law to ensure that if an adult qualifies to receive PDN, they can only receive an amount of PDN that is medically necessary.

The current process to determine the medically necessary amount of PDN is as follows: TennCare’s managed care organizations (MCOs) conduct an individual determination into the appropriate alternative services that can adequately meet the member’s needs. This may include institutional settings, and the most common institutions are nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Under prong (e) of medical necessity, TennCare’s MCOs must compare the cost of the requested PDN to the cost of the adequate alternative(s) and may only approve PDN up to the cost of the least costly alternative. While the costs of an institution may be used in the medical necessity determination, this does not mean that the member will only be approved to receive care in an institution.

In this process, the MCO first determines whether an alternate service or setting can adequately meet the member’s needs before they can complete the medical necessity decision. TennCare cannot hold a bed in a facility so this does not mean that a bed must be available at a given point in order to determine that a facility setting can adequately meet the member’s needs.

This current medical necessity process is longstanding, and this process is not being changed in the proposed rules. TennCare and its MCOs will continue to follow these processes going forward.

### 4) What is TennCare changing with the proposed rules?

While the process for determining medical necessity is not changing, TennCare is proposing changes to “lock in” or freeze the rates used in the existing process. This will provide certainty and consistency to members who receive PDN.

As explained in FAQ No.3 above, TennCare must consider several costs including the cost of PDN and the cost of care in an appropriate facility to accurately determine the least costly alternative under state law. These costs are determined annually based on experienced costs in the market. For the past few years, the hourly cost of PDN has been rising much faster than the cost of care in different institutional settings. As this trend continues, TennCare anticipates that members will receive less PDN hours than a member is eligible for as part of the current medical necessity determination process. This proposed rule allows TennCare to establish the authority to lock the current rates to determine medical necessity which will provide consistency to members. Without this proposed rule, the cost of PDN services continue to rise faster than the cost of an institution, resulting in less PDN hours determined to be medically necessary.



In addition, TennCare is providing greater clarity to the existing medical necessity prong (e) process through this proposed rule. The existing process for how to determine medical necessity, including prong (e), is not changing with the proposed rules. However, given the impacts from changes in costs and the complexity of the PDN benefit, TennCare believes providing more detail around the existing process will better support members and providers who are navigating the PDN benefit as they turn 21.

## 5) Do the rules mean a member will lose PDN and move to an institution?

No. TennCare does not force members to receive care in an institution, and no member is ever presented with only an institutional care option. TennCare will continue to cover PDN up to the amount that is medically necessary as required by state law.

TennCare's MCOs offer multiple care coordination planning meetings, both in-home and virtually, to help members understand their care options and to determine what services and programs may best meet their needs. During this process, all members who are eligible for PDN services are also presented with options that include home and community-based programs that can provide additional services to facilitate independence and community integration. See FAQ No. 8 below for more information about this care transition process. Through its commitment to providing community options and supporting care transition planning, TennCare has significantly reduced institutionalization over the last fifteen years. The proposed rules do not change this dedication to ensuring members are served in the most appropriate and integrated setting.

## 6) Why does PDN change at age 21?

Under federal law known as EPSDT (Early and Periodic Screening, Diagnostic, and Treatment), Medicaid programs must provide more comprehensive services to children than adults. Beginning at age 21, EPSDT no longer applies, and Medicaid programs may provide different benefit coverage to adults.

To continue receiving PDN as an adult, a TennCare member must meet certain criteria defined in TennCare's waiver and rules, and the amount of PDN must be medically necessary as required in state law and described above. These are long-standing requirements that are not being changed with the proposed rules.

## 7) What does TennCare do to help members, and their families prepare for the changes to PDN as they reach age 21?

Beginning at age 18, TennCare requires MCOs to help members and their families prepare for changes to services that will take effect at age 21. This requirement mandates the MCOs to coordinate and to collaborate with all members receiving PDN that are likely to see a change in PDN services when they turn age 21. The purpose of this requirement is to prepare members and their families for the transition from PDN benefits the member received as a child to the benefits the member may receive



as an adult. The MCOs, in collaboration with TennCare, provide education to the member and their family that include member handbooks, phone calls, and in-person meetings, to explain upcoming benefit changes and availability of additional home and community-based services and other alternatives that are available with TennCare's LTSS programs. More information on these programs can be found on TennCare's [LTSS website](#).

## 8) Can a member challenge a medical necessity decision?

Yes. If a TennCare MCO makes a medical necessity decision and the member is not in agreement, they can file an appeal and get a hearing. Information on how to file an appeal – and keep services during the appeal – is included on the notice explaining the medical necessity decision.