STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Screening for CHOICES Eligibility/Enrollment
Effective Date	July 1, 2012

Background:

Given the demographics of the aging population and continuing advances in medical technology, the numbers of persons seeking long-term care services will grow exponentially over the next few decades. The CHOICES Program offers some of those persons assistance in meeting their long-term care needs.

However, not everyone who wants or needs long-term care will qualify for CHOICES—financially and/or medically (i.e., functionally, based on established nursing facility level of care requirements). Persons seeking home and community based services (HCBS) may not meet the State's target criteria for CHOICES Group 2, namely those criteria set forth in the Section 1915(c) HCBS Waiver which existed prior to implementation of CHOICES and which are carried forward into the State's Section 1115 Demonstration Waiver, (i.e., persons age 65 and older and adults age 21 and older with physical disabilities). Or, they may not qualify in one of the Medicaid eligibility groups set forth in the Section 1915(c) HCBS Waiver which existed prior to implementation of CHOICES and which are also carried forward into the State's Section 1115 Demonstration Waiver, (i.e., persons currently SSI eligible and persons eligible in an Institutional eligibility category by virtue of being enrolled in and receiving HCBS waiver services). Further, some persons who want to receive HCBS may have such significant caregiving needs that delivery of services in the home or community setting cannot be safely and cost-effectively achieved. Finally, some persons who may qualify for CHOICES may ultimately elect to not participate in CHOICES once they understand Federal Estate Recovery Program (FERP) requirements.

Whether conducted by the Single Point of Entry (SPOE) for non-Medicaid eligible persons seeking enrollment into CHOICES, or by the MCO for existing Medicaid-eligible members, the CHOICES intake process (which is in most cases conducted face-to-face in the member's place of residence) takes several hours. In order to target both SPOE (i.e., Area Agency on Aging and Disabilities or AAAD) and MCO staff resources to those persons likely to actually qualify for CHOICES enrollment and to expedite their timely access to services, a screening process may be used by the AAAD or MCO to help identify upon initial contact or identification, whether a full intake process is likely needed.

A screening process is not an eligibility determination. Any person screened based upon a referral for enrollment into CHOICES will have the opportunity to proceed with the CHOICES intake process, and if determined not eligible for enrollment into CHOICES, to receive notice of the decision, and due process rights to a fair hearing regarding the reason(s) s/he does not qualify.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Screening for CHOICES Eligibility/Enrollment
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Requirements:

Applicable CRA references include:

TennCare's Grant Contract with each AAAD sets forth in Sections A.14 through A.17 specific requirements pertaining to the SPOE's screening process.

The MCO Contractor Risk Agreement (CRA) also sets forth in Section 2.9.6.2.3.1 an explanation of the screening process that will be used by the Single Point of Entry (SPOE) for non-Medicaid eligible persons seeking enrollment into CHOICES.

2.9.6.2.3.1. .

The CRA further sets forth in Sections 2.9.6.3.2 through 2.9.6.3.7 requirements for MCOs regarding screening of their existing members for enrollment into CHOICES.

2.9.6.3.2.- 2.9.6.3.7.

Protocol:

This Screening for CHOICES Eligibility/Enrollment Protocol sets forth specific requirements and processes regarding screening for eligibility and/or enrollment into the CHOICES program, and the responsibility of the AAADs in performing such screening for non-Medicaid eligible persons seeking enrollment into CHOICES and the responsibility of MCOs in performing such screening for their current members.

CHOICES Groups

There are three **(3) CHOICES Groups**:

CHOICES Group 1 consists of persons who are ***receiving*** Medicaid-reimbursed care in a Nursing Facility (NF). This includes persons who are eligible for Medicaid in *any* eligibility category regardless of age or condition, so long as such persons meet NF level of care.

CHOICES Group 2 consists ***only*** of persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care, and who qualify either as SSI recipients or in an Institutional category (i.e., as members of the 217-Like demonstration population), and who need and are *receiving* HCBS as an alternative to NF care.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Screening for CHOICES Eligibility/Enrollment
Effective Date	July 1, 2012

CHOICES Group 3, upon implementation will consist ***only*** of persons age 65 and older and adults age 21 and older with physical disabilities who do not meet the nursing facility level of care, but who, in the absence of HCBS, are "at risk" for nursing facility care, and who qualify for TennCare as SSI recipients. CHOICES Group 3 recipients will receive a more limited package of HCBS services to help meet their needs and maintain their lifestyle in the community Please note that except individuals with conditional Group 3 enrollment, all individuals enrolled into CHOICES Group 3 between the date of implementation and December 31, 2013 will be enrolled into the Interim CHOICES Group 3.

Interim Group

Interim CHOICES Group 3, (open for new enrollment only between the date of CHOICES Group 3 implementation and December 31, 2013) Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of At Risk Demonstration Group and who meet the NF LOC criteria in place as of the date immediately preceding the date of CHOICES Group 3 implementation (i.e., if CHOICES Group 3 is implemented on July 1, 2012, "at risk" criteria is the NF LOC in place on June 30, 2012). There is no enrollment target on Interim Group 3.

There are specific requirements for enrollment into each CHOICES group. However, some requirements are applicable across all groups. These include level of care eligibility for long-term care and categorical and financial eligibility for Medicaid reimbursement of long-term care (in the case of HCBS, limited to certain eligibility categories). Further, FERP requirements must be applied to all persons receiving nursing facility services and to persons age 55 and older across all long-term services and supports.

Categorical and Financial Eligibility for Reimbursement of Long-Term Care Services

To receive nursing facility services in CHOICES, a person must qualify for Medicaid-reimbursement of long-term services and supports, including requirements pertaining to the Deficit Reduction Act of 2005 regarding asset transfer. To receive home and community based services, a person must be SSI eligible (including persons who have recently lost SSI eligibility and are in process of determination for Medicaid eligibility pending such determination), qualify under the State's 217-Like demonstration population, which parallels Institutional eligibility requirements for persons enrolled in a Section 1915(c) HCBS Waiver and receiving HCBS pursuant to 42 CFR 435.217, or qualify as a member of the At Risk Demonstration Group.

To satisfy categorical and financial eligibility criteria for CHOICES, a person must:
- Live in Tennessee
- Intend to remain in Tennessee
- Be a U.S. Citizen or a U.S. National (and provide qualified documentation thereof)

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Screening for CHOICES Eligibility/Enrollment
Effective Date	July 1, 2012

- Have income less than $2,094 per month or establish a Qualifying Income (or Miller) Trust which names the State as the beneficiary
- Have resources less than $2,000
- Have not transferred assets for less than fair market value in the last 5 years except as permitted under the DRA of 2005
- Have an approved CHOICES level of care determination (i.e., PAE)
- Be ***admitted*** to a NF or ***approved*** by TennCare for immediate enrollment into CHOICES Group 2 or 3 (HCBS), subject to financial and categorical eligibility (***qualifying*** for enrollment into CHOICES Group 2 or 3 is **not** sufficient if the person will not actually *be* ***enrolled*** and ***start receiving*** HCBS)

Level of Care Eligibility for Long-Term Services and Supports

To satisfy level of care eligibility for CHOICES **Groups 1 or Group 2**, a person must satisfy both of the following criteria:

1. Medical necessity of care
    a. For Group 1 this means that NF care is expected to improve or ameliorate the individual's physical or mental condition, to prevent deterioration in health status, or to delay progression of a disease or disability.
    b. For Group 2 this means that HCBS is required in order to allow the person to continue living safely in the HCBS setting and to prevent or delay placement in a nursing facility. and the need for inpatient nursing care.
2. Need for Inpatient Nursing Care (for more information refer to protocol entitled *Determining the Need for Inpatient Nursing Care*)
    a. For Group 1 this means that the individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform the needed nursing care and must meet at least one of the following criteria:
        i. A total score of nine (9) or more on the TennCare NF LOC Acuity Scale, or
        ii. Meet one or more of the ADL or related criteria as delineated in the above referenced protocol AND be determined by TennCare to not qualify for enrollment into CHOICES Group 3.
    b. For Group 2 this means that the individual must have a physical or mental condition, disability or impairment that requires ongoing supervision and/or assistance with ADLs in the HCBS setting. In the absence of ongoing HCBS, the person would require and must qualify to receive NF services in order to remain eligible for HCBS in Group 2. The individual must be unable to self-perform the needed nursing care and must meet at least one of the following criteria:
        i. A total score of nine (9) or more on the TennCare NF LOC Acuity Scale, or

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Screening for CHOICES Eligibility/Enrollment
Effective Date	July 1, 2012

ii. Meet one or more of the ADL or related criteria as delineated in the above referenced protocol AND be determined by TennCare to not qualify for enrollment into CHOICES Group 3.

To satisfy level of care eligibility for CHOICES **Group 3**, a person must have a physical or mental condition, disability or impairment that requires ongoing supervision and/or assistance with ADLs in the HCBS setting. In the absence of ongoing HCBS, the person would not be able to live safely in the community and would be at risk for NF placement. The individual must be unable to self-perform the needed nursing care and must require the ongoing provision of hands-on physical assistance on a daily basis, or the majority of days each week, in one or more of the following areas:

- Transfer
- Mobility
- Eating
- Toileting
- Expressive and Receptive Communication
- Orientation
- Medication Administration
- Behavior
- Skilled Nursing and/or Rehabilitation

Please note that while screening for level of care eligibility may be conducted over the phone, an actual level of care assessment must be completed face-to-face with the person, and requires a more in-depth interview of the person as well as family members and other caregivers (as applicable), review of medical records and other documentation, and direct observation of the person's functional abilities and deficits. This requirement applies to all CHOICES groups.

Additional Eligibility/Enrollment Criteria for Persons Seeking HCBS

While the above criteria are applicable across all long-term care services available under CHOICES, pursuant to the terms and conditions of the State's approved Section 1115 Demonstration Waiver, additional eligibility/enrollment criteria apply to persons seeking access to home and community based care.

CHOICES Group 2 and Group 3 (HCBS) Target Criteria

To satisfy target criteria for enrollment into CHOICES Group 2 (HCBS), a person must be:
• Age 65 and older; or

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Screening for CHOICES Eligibility/Enrollment
Effective Date	July 1, 2012

• Age 21 and older and have physical disabilities.

No enrollment target will be applied to CHOICES Group 3 prior to January 1, 2014.

Safety and Cost Neutrality Requirements in a Home and Community-Based Setting

To satisfy requirements regarding safety and cost-neutrality, the MCO must make a determination that the persons' needs can be safely and effectively met in the home and community-based setting, and, in the case of Group 2, the MCO must determine that the persons' needs can be met at a cost that does not exceed the average cost of the level of nursing facility reimbursement that would be paid if the person were institutionalized.

While the level of care for Group 2 is NF level of care, under CHOICES, each Group 2 member will have an individual cost neutrality cap that is based on the average cost of the level of NF reimbursement that would be paid if the member were institutionalized.

- A member that would qualify only for Level I NF reimbursement shall have a cost neutrality cap set at the average cost of Level I NF care.
- A member that would qualify for Level II (or skilled) NF reimbursement shall have a cost neutrality cap set at the average cost of Level II (or skilled) NF care.
- A member that would qualify for one of the enhanced respiratory care rates (i.e., for persons who are chronically ventilator dependent, or who have a functioning tracheotomy that requires frequent suctioning through the tracheotomy) will have a cost neutrality cap that will reflect the higher payment that would be made to the NF for such care.

Each Group 3 member will have an expenditure cap of fifteen thousand ($15,000) per year to provide the CHOICES HCBS services and supports required to help the individual meet their needs.

Such determination must take into account the type and amount of assistance that will be needed to safely meet the person's needs in the home or community setting, the availability of family and other caregivers to meet those needs, the amount of paid supports that will be required, and in some instances for Group 2 participants, the person's willingness to receive services in a Community Based Residential Alternative setting, including companion care in the person's home, in order for his/her needs to be safely and cost-effectively met.

Continued Interest in CHOICES Enrollment based on FERP Requirements

While Federal Estate Recovery Program requirements do not constitute eligibility criteria for enrollment into CHOICES per se, because all persons enrolled in CHOICES are subject to applicable FERP

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Screening for CHOICES Eligibility/Enrollment
Effective Date	July 1, 2012

requirements, and due to the large volume of persons who opt out of long-term care services upon learning of FERP requirements, screening for eligibility/enrollment into CHOICES will include an explanation of FERP requirements in order to confirm that the person remains interested in pursuing CHOICES enrollment.

Screening for CHOICES Eligibility/Enrollment

All AAADs and MCOs conducting screening for CHOICES Eligibility/Enrollment shall proceed in accordance with this protocol. The screening tool utilized by AAADs is the ***Omnia HCBS LTC Intake Screening Form*** currently used by AAADs for all referrals and tracked through the SAMS system. MCOs will utilize a screening tool provided by TennCare.

This CHOICES eligibility/enrollment screening process has been designed to be conducted over the phone. Whenever possible and as applicable, the screening should be conducted by the AAAD or MCO at the point of referral for long-term care services, (i.e., at the time a telephone referral is received, so long as the person making the referral is either the applicant or member, as applicable, or a person authorized by the applicant or member, as applicable, to complete such screening on his/her behalf). When the screening cannot be completed at the time of referral, the AAAD or MCO must complete such screening within the timeframes specified in their respective contracts with TennCare, (i.e., two (2) business days from receipt of referral for the AAAD, and ten (10) business days of referral for completion of the screening ***and*** intake assessment for MCOs).

When completion of the screening cannot be accomplished at the point of referral and the AAAD or MCO is unable to reach the applicant or member, as applicable, to complete the screening timely, the entity's obligations for timely screening shall be met by documentation of at least three (3) attempts to contact the member by phone (which for the MCO, shall include at least one (1) attempt to contact the member at the number most recently reported to the MCO by the member and at least one (1) attempt to contact the member at the number provided in the referral, if different), followed by a letter sent to the member's most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES.

For the MCO, screening as well as intake (as applicable) for referrals obtained through notification of hospital admission shall be completed immediately in order to facilitate timely transition to the most integrated and cost effective long-term service and supports delivery setting appropriate for the member's needs.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Screening for CHOICES Eligibility/Enrollment
Effective Date	July 1, 2012

For persons identified by the MCO that may be eligible for CHOICES by means other than referral or notice of hospital admission (e.g., mining of claims or encounter including pharmacy data), the MCO must complete such screening as expeditiously as possible (there is no specific timeframe).

If the MCO is unable to reach the member identified through means other than referral or notice of hospital admission, the MCO's obligations for screening shall be met by documentation of at least one (1) attempt to contact the member by phone at the number most recently reported by the member, followed by a letter sent to the member's most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES.

Persons who Fail Screening Criteria

If the applicant or member, as applicable, does not meet the telephone screening criteria, the AAAD or MCO, as applicable, shall notify the applicant or member verbally and shall issue a written notice, using the template provided by TennCare which advises: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including a due process right to appeal; and (3) how, if s/he wishes to proceed with the CHOICES intake process, s/he can submit a written request to proceed with the CHOICES intake process to the AAAD or MCO, as applicable.

In the event that the person does submit such written request, the AAAD or MCO, as applicable, shall conduct a face-to-face intake visit within five (10) business days of receipt of the written request.

Screening Documentation Requirements

All telephone screenings shall be documented, as well as their disposition, with a written/electronic record.