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	CHOICES Transitions from NF to HCBS
Effective Date	July 1, 2012

Background

CHOICES is made up of three (3) groups, each with distinct eligibility/enrollment requirements and benefits.

CHOICES Group 1 consists of persons who are ***receiving*** Medicaid-reimbursed long term services and supports (LTSS) 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 which includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities), and who need and are ***receiving*** HCBS as an alternative to NF care.

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 NF LOC, but who, in the absence of HCBS, are "at risk" for NF care, and who qualify for TennCare as SSI recipients (please refer to Interim CHOICES Group 3 definition for alternate TennCare eligibility criteria that will be in place from the date of Group 3 implementation through December 31, 2013). CHOICES Group 3 recipients will receive a more limited package of HCBS services to help meet their needs, maintain their lifestyle in the community, and to prevent or delay the need for institutional care. 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.

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	CHOICES Transitions from NF to HCBS
Effective Date	July 1, 2012

A member's enrollment into Group 1 or Group 2/3 is determined in part by a member's decision regarding freedom of choice of institutional versus home and community-based services. Members are presented with such choice upon entering the CHOICES program. The member will be asked if they are interested in receiving needed services in their home or other community setting or if they wish to receive services in a nursing facility. The care coordinator will assist the member in making this choice by answering the member's questions and educating the member about services that are available to them in the community.

Freedom of choice does not end at the member's initial decision, however. To enroll in a particular CHOICES group and to thus receive the institutional or HCBS benefits available for group participants, a person must satisfy all applicable eligibility and enrollment criteria for the group. To remain enrolled in the group, the person must continue to satisfy all applicable eligibility and enrollment criteria. If a member is enrolled in a CHOICES group and subsequently no longer meets eligibility and/or enrollment criteria to remain enrolled in that group, a member may ***elect*** to transition to another CHOICES group if s/he qualifies to enroll in that group, thereby exercising his/her freedom of choice to receive long-term care services in a different service delivery setting. Further, a member may ***elect*** to transition between CHOICES groups based on his or her preferences, or changes in needs and/or circumstances.

Transitioning between CHOICES groups is not merely the act of moving from one care setting to another; it is a process that includes eligibility, enrollment and care coordination functions; occurs over time; and ensures that the CHOICES member receives needed LTSS in the appropriate setting with no gaps in service.

Requirements

Applicable CRA references include:

2.9.6.5 Needs Assessment
2.9.6.6 Plan of Care
2.9.6. 9 On-going Care Coordination

In addition to requirements specified in the Contractor Risk Agreement (CRA), CHOICES eligibility and enrollment criteria are set forth in federal and state law and regulation and the approved Section 1115 Waiver application.

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DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS
OPERATIONAL PROTOCOL

Protocol Title	CHOICES Transitions from NF to HCBS
Effective Date	July 1, 2012

It is the responsibility of the MCO to monitor whether CHOICES members continue to meet certain CHOICES eligibility and enrollment criteria, namely requirements pertaining to target population; safety and/or cost neutrality/expenditure cap; and payment of patient liability, and to take action to resolve issues when they are identified so that a member may continue to qualify for and remain enrolled in CHOICES, which may involve transition to a different service delivery setting, and/or transition to a different CHOICES group.

Finally, an MCO is obligated to honor a member's right to exercise his/her freedom of choice regarding receipt of institutional versus HCBS, so long as s/he satisfies all applicable eligibility/enrollment criteria for receipt of services in the applicable setting and for enrollment in that CHOICES group.

Protocol

This protocol establishes specific expectations regarding the responsibilities of the MCO regarding the transition of members between CHOICES Group 1 to Group 2 or 3.

Transition from Group 1 to Group 2

An MCO may request to transition a member from Group 1 to Group 2 ***only*** when the member ***chooses*** to transition from the NF to a home and community-based setting and continue to meet the LOC criteria in place at the time of admission. Even when the MCO believes that care in the community could be provided more cost-effectively than in a NF, if the member qualifies for NF care and elects to receive NF care, s/he cannot be required to transition from Group 1 to Group 2 and begin receiving HCBS.

In order to transition to CHOICES Group 2 a member must:

- continue to meet NF LOC criteria in place at the time of admission
- be in one of the target populations
- have an approved, unexpired PAE (CHOICES, NF or HCBS)
- have an approved safety and cost neutrality determination
- be Medicaid eligible in an active SSI or institutional category (no asset transfer penalty period)
- be within enrollment target or meet specified exception (NF Transition or CEA)

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	CHOICES Transitions from NF to HCBS
Effective Date	July 1, 2012

Transition from Group 1 to Group 3

An MCO may request to transition a member from Group 1 to Group 3 ***only*** when a change in level of care has occurred such that the member no longer meets NF LOC but the At Risk LOC for Group 3. As long as the member continues to meet an unexpired NF LOC in place at the time of admission (i.e. Grandfathered status) without a loss in Medicaid coverage or level of care change, he/she may stay in Group 1. If the member is enrolled into CHOICES Group 1 on or after July 1, 2012, or has an experied PAE and is reassessed under the new LOC care requirements set forth July 1, 2012, and no longer meets the NF LOC but does meet the At Risk LOC then they will be transitioned from Group 1 to Group 3.

In order to transition to CHOICES Group 3 a member must:

- meet At Risk LOC criteria
- have an approved, unexpired PAE (CHOICES, NF or HCBS)
- have an approved safety determination
- be Medicaid eligible in an active SSI or 217-Like MOE category

Conditional Enrollment for Group 1

Conditional enrollment occurs for CHOICES Group 1 enrollment requests when a non-Medicaid eligible individual is admitted to a nursing facility (NF) and has been approved for NF level of care (LOC) through the Advance Determination process (refer to the *Determining the Need of Inpatient Nursing Care (Advance Determination) Protocol* to clarify this process). The Medicaid Only Payer Date (MOPD) from the submitter is required before forwarding the approved PAE to DHS for a financial eligibility determination. Once the applicant is Medicaid eligible and enrolled in CHOICES Group 1, the MCO will receive an 834 file indicating CHOICES enrollment for a period of 30 days. The member will be indicated as a CHOICES Group 1A-c and/or 1B-c member.

Transition from Group 1A-c and/or 1B-c to Group 3A-i

Before CHOICES conditional enrollment expires, the MCO must submit to TennCare a CHOICES Conditional Enrollment Transition request via TPAES. If the MCO determines that the member's needs can be safely met through CHOICES Group 3, a CHOICES Group 1A-c and/or 1B-c to Group 3A-i transition request will be initiated.

The transition process from Group 1A-c and/or 1B-c to Group 3A-i consists of the following:

- MCO must submit a CHOICES Conditional Enrollment Transition request via TPAES;
- In order to transition to CHOICES Group 3A-i a member must:
  - meet At Risk LOC criteria;
  - have an approved, unexpired PAE (CHOICES, NF or HCBS);
  - have an approved safety determination;
  - be Medicaid eligible in an active SSI or 217-Like MOE category;
- If approved, the MCO will receive an 834 file indicating CHOICES enrollment for group 3-Ai and Tenncare will history the Group 1 conditional assignment and make the Group 3 assignment effective retroactively.

Transition from Group 1A-c and/or 1B-C to group 1A-r and/or 1B-r

If the MCO determines that the member's needs can NOT be safely met through CHOICES Group 3 and is requesting a Group 1 PAE approval through an Advanced Determination process, a CHOICES Group 1A-c and/or 1B-c to Group 1A-r and/or 1B-r transition request will be initiated and must include supporting documentation.

The transition process from Group 1A-c and/or 1B-c to Group 1A-r and/or 1B-r consists of the following:

- MCO must submit a new PAE for CHOICES Group 1 through the Advanced Determination process;
- To qualify for Advanced Determination an applicant must meet the following guidelines:
  - The applicant has a total acuity score of at least six (6) but no more than eight (8);
  - The applicant has an individual acuity score of at least three (3) for the Orientation measure;
  - The applicant has an individual acuity score of at least two (2) for the Behavior measure;
  - The absence of intervention and supervision at the frequency specified in the PAE would result in imminent and serious risk of harm to the applicant and/or others;
  - Sufficient evidence, as required and determined by TennCare, to demonstrate that the necessary intervention and supervision needed by the person cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services

available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers;

- To initiate the transition request the following supporting documentation must be submitted:
  - A comprehensive needs assessment performed by an MCO Care Coordinator pursuant to requirements set forth in the MCO's Contractor Risk Agreement;
  - A person centered plan of care developed by the MCO Care Coordinator which specifies the CHOICES HCBS that would be necessary and that would be approved by the MCO to safely support the person in the community, including non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers;
  - Explanation regarding why an array of covered services and supports, including CHOICES HCBS within the $15,000 expenditure cap for CHOICES 3 and non-CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the person's needs in the community;
  - Detailed explanation of: a) the member's living arrangements and the services and supports the member has received for the six (6) months prior to application for CHOICES, including non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers; and b) any recent significant event(s) or circumstances that have impacted the applicant's need for services and supports, including how such event(s) or circumstances would impact the person's ability to be safely supported within the array of covered services and supports that would be available if the person were enrolled in CHOICES Group 3;
- If approved, the MCO will receive an 834 file indicating CHOICES enrollment for group 1A-r and/or 1B-r and Tenncare will history the Group 1 conditional assignment and make the Group 1 regular assignment effective retroactively.

Member Identification

MCOs must use a variety of methods to identify eligible CHOICES Group 1 members who may be interested in and have the ability to transition to the community. At a minimum, these methods include

referrals from any source (e.g., self, NF, family, providers, or community-based organizations), the care coordination process, and review of Minimum Data Set (MDS) data from nursing facilities. Upon CHOICES enrollment and again at least annually, the care coordinator must assess each Group 1 member's potential interest in and ability to transition to the community (CRA 2.9.6.5.1.1). While this is one way in which the care coordination process may identify members for transition, other aspects of the process, such as Grand Rounds and interaction with the NF staff, are also valuable resources for the care coordinator.

Transition Screening

When a Group 1 member is identified as a possible candidate for transition, the care coordinator must conduct a face-to-face visit in the facility with the member and complete a *transition screening* (see the CHOICES *Needs Assessment* Protocol which delineates specific requirements for the transition screening*)*. For members identified via referral or level of care expiration, the care coordinator must complete the face-to-face visit and transition screening within *fourteen (14) days* of the lesser of either the receipt of the referral or the expiration of the level of care determination. For members identified through any means *other than* referral or the care coordination process, the face-to-face visit and transition screening must occur within *ninety (90) days* of member identification.

Transition screening is an interactive process during which the care coordinator

- Evaluates the member's interest in and potential ability to transition to the community;
- Assess member's level of care to determine the CHOICES group the member may be enrolled into to receive home-based care
- Provides the member with information and education about the community transition process; and
- Assesses the member's potential eligibility to participate in TennCare's Money Follows the Person (MFP) national demonstration project. (see CRA Section 2.9.8 and the ***MFP Transition Protocol*)**.

In addition to assessing the member's interest in transitioning, this screening is a first step in determining a member's ability to successfully transition to the community. While making this determination, the care coordinator must consider many factors, including the member's potential care needs and natural support system, community resources and available TennCare services for which the member may be eligible (e.g. disease management, case management and transition allowance).

The care coordinator's discussion with the member detailing the member's wishes regarding and potential ability to transition to the community must be documented in the member's CHOICES record. If the member wishes to pursue transition to the community, the next step in the process is the Transition Assessment.

The MCO *will not* require a CHOICES Group 1 member to transition to HCBS when the CHOICES member chooses to continue receiving nursing facility services as long as the member continues to meet the level of care in place at the time of admission   If the member no longer meets this level of care they will be enrolled into CHOICES group 3.

Transition Assessment

When the transition screening indicates that the CHOICES member has the potential ability to, and interest in, community transition and the member appears to meet the appropriate criteria, the care coordinator must complete a *Nursing Facility to Community Transition Assessment* (see the CHOICES *Needs Assessment Protocol*). The transition assessment provides detailed information that will assist the member and the care coordinator/care coordination team in determining if the member is able to transition to the community. Should the member pursue community transition, the transition assessment will be a resource for the care coordinator as s/he and the member work together to develop a transition plan. The minimum elements of a transition assessment are delineated in the *Needs Assessment* protocol, and include assessment of the following:

- Physical, behavioral, and long-term health care needs;
- Natural supports;
- Housing or home modification needs which shall include an in-person assessment of the member's community residence by the care coordinator;
- Financial ability to maintain a safe living environment and the need for a transition allowance at the time of transition;
- Risk associated with living in the community and receiving home and community based services as an alternative to nursing facility care; and
- Safety and in the case of Group 2 participation, cost neutrality.

For members identified for potential transition via the care coordination process, the care coordinator must complete the transition assessment within *fourteen (14) days* of identification. For members

identified through any other method, the transition assessment must be completed within *fourteen (14) days* of the initial screening visit. Using only the tools approved by TennCare the care coordinator must complete the transition assessment with the member in the facility and his/her representative as appropriate. Additionally, the member may choose to include other important people (e.g., family or friends) in the assessment and planning processes. The two primary components of the transition assessment are the risk assessment and comprehensive needs assessment, and these provide the basis for the following:

- Member's understanding and decision regard acceptance of the level of risk associated with transition and development of a risk agreement;
- Care coordinator/care coordination team's determination regarding whether the individual's needs can likely be met safely and, in the case of Group 2 participation, cost-effectively; and
- Transition Plan development.

The *risk assessment* is one of the most important aspects of the transition assessment (see CHOICES Protocol entitled *Risk Assessment and Planning*). During this process, the care coordinator begins discussing with the member/representative the risks associated with receiving HCBS as an alternative to NF. If the member wishes to continue with the potential community transition, the care coordinator develops a person-specific *risk agreement* that includes identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk. The relationship between the member and care coordinator is especially important when transitioning to the community and requires more than just the minimum number of required contacts. Additional contacts allow the care coordinator to identify and respond quickly to changing or new risks or barriers to a successful transition. The risk agreement must indicate the frequency and type of care coordinator contacts that exceed the minimum that will occur and any other special circumstances associated with the member's transition.

The care coordinator must discuss the risk agreement with the member and answer questions the member may have about the information. The member must then decide if s/he is willing to accept the associated risks and pursue transition. For Group 2 participation, the member/representative must sign *and* date the risk agreement to document his/her decision. If the member determines that the level of risk is too high, the process will terminate at this point, but at least annually, the care coordinator will reassess the member's interest in and ability to transition. When the member understands and is willing to accept the level of risk involved with transition to the community, the MCO *may not* refuse to transition the member due to the level of risk.

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	CHOICES Transitions from NF to HCBS
Effective Date	July 1, 2012

The risk agreement is not a static document. While risk assessment and planning begins during the Transition Assessment, they continue throughout the transition process and ongoing care coordination activities. As needed, the care coordinator will update the risk agreement so that it accurately reflects the level of risk associated with the member's decision to leave the NF and instead receive HCBS services. The care coordinator must discuss each amendment to the risk agreement with the member, and the member/representative must sign and date each to document his/her continued acceptance of the level of risk.

Group 1 to Group 2 Transitions and Cost Neutrality Determinations

In addition to the risk agreement, the transition assessment provides information that the care coordinator/care coordination team needs to determine if a member's needs can be safely met in the community. For Group 2 participation this must also include a consideration that the members need's can be met in the community at a cost that does not exceed the member's individual cost neutrality cap (see *Individual Cost Neutrality Cap* Protocol). This determination must take into account the type and amount of HCBS, Medicaid-reimbursed home health, and private duty nursing that will be needed to safely meet the member's *unmet* needs in the home or community. That is, when considering the natural supports and other resources available to the member, what additional services will likely be required in order to safely meet the member's needs.

The care coordinator will provide the member/representative with information about his/her individual cost neutrality cap and explain that the cost of the HCBS services that are needed to safely meet his/her needs in the community must not exceed the member's individual cost neutrality cap. In addition, the care coordinator must discuss with the member that in the future, if the member's needs change and the cost of the services required to safely meet his/her needs exceeds the individual cost neutrality cap, the member will no longer be eligible for CHOICES Group 2. If this occurs, the member should be assured, the care coordinator will assist him/her in making transitions that are necessary in order to receive the needed services for which the member is eligible.

When the care coordinator/care coordination team determines that the member's needs *cannot* be met safely in the community and/or within the cost neutrality cap, the transition cannot be denied without prior review and approval by TennCare LTSS (see subsequent section entitled *Transition Denial*).

If the member is a candidate for transition, and the member wishes to transition from the NF to the community, the care coordinator will begin developing the transition plan.

Transition Planning

Within *fourteen (14) days* of the transition assessment, the care coordinator must develop a *transition plan* (see *Plan of Care* protocol). Using the information gathered through the transition assessment and from other sources (e.g., family members and NF staff) and, based on the member's needs, the transition plan describes all the services and supports that will be needed to successfully transition the member to the community. At a minimum the transition plan must identify the member's transition-related needs related to housing, transportation, and available caregivers; services and supports needed to meet the identified needs; and possible barriers to transition and strategies to overcome the barriers. The transition plan is not a static document and should be updated as appropriate to accurately reflect the member's transition.

Prior to the member's actual move to the community, the care coordinator must visit and evaluate the physical residence where the member will live and, as appropriate, meet the family members or caregivers who will reside with the member. If the care coordinator identifies additional transition-related needs, risks or barriers, s/he must include the information in the transition plan and delineate strategies to mitigate each. The care coordinator must also update the risk agreement, as appropriate.

Within ten (10) days of the completion of the transition plan, if the MCO determines that the member's needs can safely be met in the community, the MCO must approve the transition plan, thereby approving the transition, and authorize any covered or cost-effective alternative services included in the plan. While the transition may occur much more quickly, the member's transition to the community must occur within ninety (90) days of approval of the transition plan. If this does not occur, the care coordinator/care coordination team must document the circumstances in the member's CHOICES file and actions taken to mitigate the delay.

The MCO may not deny the transition without prior review and approval by TennCare LTSS (see subsequent section entitled *Transition Denial*).

In addition to the transition plan, for implementation when the member moves to the community, the care coordinator must develop a complete *plan of care* (see CRA 2.9.6.6 and *Plan of Care* protocol) including

needs assessment, risk agreement, and/or cost neutrality determination. When the transition is approved by TennCare LTSS, and prior to the transition date, all of the covered HCBS, home health, or private duty nursing services identified in the plan of care must be authorized, and providers prepared to *immediately* deliver services to the member upon discharge from the NF. As the member moves into the community, there must be no gap in service between discharge from the NF and delivery of HCBS.

Transition

Once an MCO has determined that criteria appear to be met, a CHOICES Group transition request and cost neutrality determination will be created in TPAES (the TennCare PAE System) and submitted to TennCare for review and approval. TennCare will forward information to DHS to recalculate the member's patient liability based on his/her personal needs allowance.
Although an MCO may receive notification of approval of request to transition a member between CHOICES groups via TPAES, a member's transition between groups is not "official" until the MCO receives notification via the 834 enrollment file that the member has been enrolled in a different CHOICES group. Upon receipt of such notification via the 834 enrollment file, the MCO shall issue notice of transition between CHOICES groups to the member. Because the member remains enrolled in the CHOICES program (which includes nursing facility as well as HCBS benefits) and has *chosen* to transition between CHOICES groups, such transition shall not constitute an adverse action. Thus, the notice does not include the right to appeal or to request a fair hearing regarding the member's decision.

The care coordinator/care coordination team must monitor the entire transition and immediately address any barriers or factors that may impact the member's transition. For members who will not be residing in a community based residential alternative (CBRA), such as an assisted living, the care coordinator/care coordination team must use the EVV and other methods to monitor service delivery and to verify that the member is receiving services as described in the plan of care. Variations or gaps in services must be resolved *immediately*.

Following the member's transition, the minimum required care coordination contacts are increased. Through these enhanced contacts, the care coordinator will frequently evaluate the member to ensure that the plan of care is being followed, his/her needs are being met and there are no risks or barriers that may threaten the success of the transition.

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	CHOICES Transitions from NF to HCBS
Effective Date	July 1, 2012

The care coordinator must contact members who transition to a CBRA or who will live with a relative or caregiver within twenty-four (24) hours of the transition. This contact may be face-to-face or by phone depending on the member's needs or concerns. Within seven (7) days of the transition, the care coordinator will meet face-to-face with the member in the member's residence. For ninety (90) days following the transition, the care coordinator will call the member at least monthly and, at a minimum, will monitor the success of the transition and verify that the plan of care is being followed and it meets the member's needs. The care coordinator will make additional face-to-face visits as needed to make sure that the member's needs are met.

For members who will live independently in the community or whose home visit during transition planning indicated an increased level of risk, the care coordinator will meet face-to-face with the member in the member's residence within twenty-four (24) hours of the transition. For ninety (90) days following the transition, the care coordinator will meet face-to-face with the member in the member's residence at least monthly and, at a minimum, will monitor the success of the transition and verify that the plan of care is being followed and it meets the member's needs.

<u>Transition Denials</u>

At any point in the transition process, if the MCO determines that a CHOICES member does not meet criteria to transition to another CHOICES group, then a request for review and approval is sent to TennCare. The request must specify the eligibility and/or enrollment criteria not met and must include supporting documentation. When a transition denial requested by the MCO is denied, then the MCO is expected to facilitate the transition as necessary. When a transition denial requested by the MCO is approved, the MCO is responsible for issuing notice to the member.

If upon review, TennCare or DHS determines that a CHOICES member does not meet criteria to transition to another CHOICES group, appropriate member notice is issued by the agency making the determination.