

REQUEST  
FOR INITIAL

HOME & COMMUNITY BASED SERVICES WAIVER  
FOR THE ELDERLY AND DISABLED

UNDER SECTION 1915(c)  
OF THE  
SOCIAL SECURITY ACT

SUBMITTED: November 5, 2001

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN  
SERVICES

TO BE EFFECTIVE: May 1, 2002

**HOME AND COMMUNITY-BASED SERVICES WAIVER**

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3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

- a. \_\_\_ aged (age 65 and older)
- b. \_\_\_ disabled
- c. X aged and disabled
- d. \_\_\_ mentally retarded
- e. \_\_\_ developmentally disabled
- f. \_\_\_ mentally retarded and developmentally disabled
- g. \_\_\_ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

- a. X Waiver services are limited to the following age groups (specify):  
Adults over the age of 21  
\_\_\_\_\_
- b. \_\_\_ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- c. \_\_\_ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. \_\_\_ Other criteria. (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- e. \_\_\_ Not applicable.



- e.  Respite care
- f.  Adult day health
- g.  Habilitation
  - Residential habilitation
  - Day habilitation
  - Prevocational services
  - Supported employment services
  - Educational services
- h.  ~~Environmental accessibility adaptations~~ Minor Home Modifications
- i.  Skilled nursing
- j.  Transportation
- k.  Specialized medical equipment and supplies
- l.  Chore services
- m.  Personal Emergency Response Systems
- n.  Companion services
- o.  Private duty nursing
- p.  Family training
- q.  Attendant care
- r.  Adult Residential Care
  - Adult foster care
  - Assisted living
- s.  Extended State plan services (Check all that apply):
  - Physician services

- Home health care services
- Physical therapy services
- Occupational therapy services
- Speech, hearing and language services
- Prescribed drugs
- Other (specify):

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t.  Other services (specify):

Home Delivered Meals

u.  The following services will be provided to individuals with chronic mental illness:

- Day treatment/Partial hospitalization
- Psychosocial rehabilitation
- Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a.  When provided as part of respite care in a facility approved by the State that is not a private residence (~~hospital, NF, foster home~~, or community residential facility).
  - b.  Meals furnished as part of a program of adult day health services.
  - c.  When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
    - 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
    - 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
    - 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
  - b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
  - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and
  2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
  - e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
  - f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
  - g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
  - h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.
  - i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes                      b.      No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted

to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a.  Yes                      b.  No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.
19. An effective date of May 1, 2002 is requested.
20. The State contact person for this request is Gail Thompson, who can be reached by telephone at (615) 741-0218.
21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: \_\_\_\_\_  
Print Name: Mark Reynolds  
Title: Deputy Commissioner, Bureau of TennCare  
Date: \_\_\_\_\_

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

The waiver will be operated by Tennessee Commission on Aging, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

The waiver will be operated by \_\_\_\_\_, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a.  X  Case Management

X  Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for development of the plan of care and for ongoing monitoring of the provision of services included in the individual's plan of care.

1.  X  Yes                      2. \_\_\_ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.  X  Yes                      2. \_\_\_ No

\_\_\_ Other Service Definition (Specify):

b.  X  Homemaker:

\_\_\_ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the

individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

X

Other Service Definition (Specify):

Homemaker Services - services consisting of general household activities and chores (e.g., sweeping, mopping, dusting, making the bed, washing dishes, personal laundry, ironing, mending, and meal preparation and/or education about the preparation of nutritious appetizing meals; assistance with maintenance of a safe environment) and errands essential to the Enrollee's care (e.g., grocery shopping, having prescriptions filled) provided by a trained homemaker when the enrollee is unable to perform such activities and when the individual regularly responsible for these activities is unable to perform such activities for the Enrollee.

c.      Home Health Aide services:

    

Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

    

Other Service Definition (Specify):

\_\_\_\_\_

\_\_\_\_\_

d. X Personal care services:

    

Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

X

Payment will not be made for personal care services furnished by a member of the individual's family.

Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

A registered nurse, licensed to practice nursing in the State.

A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

Case managers

Other (Specify):

Individual with a Bachelor's degree in a social services field ( years of social service administrative experience may be substituted for college years)

3. Frequency or intensity of supervision (Check one):

As indicated in the plan of care

Other (Specify):

Supervision of personal care assistants will be provided by the agency providing the service as indicated in 2 above. Supervisory visits will be conducted by the agency supervisor every 30 days. For additional monitoring, case managers will be required to report to the agency supervisor any quality assurance issues identified during case management visits.

4. Relationship to State plan services (Check one):

Personal care services are not provided under the approved State plan.

Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

Other service definition (Specify):

Personal Care Services - services provided to assist the Enrollee with activities of daily living, and related essential household tasks, (e.g. making the bed, washing soiled linens or bedclothes that require immediate attention), and other activities that enable the Enrollee to remain in the home, as an alternative to Nursing Facility care, including the following:

1. Assistance with activities of daily living (e.g., bathing, grooming, personal hygiene, toileting, feeding, dressing, ambulation);

2. Assistance with cleaning that is an integral part of personal care and is essential to the health and welfare of the Enrollee;

3. Assistance with maintenance of a safe environment.

e.  Respite care:

\_\_\_ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

X Other service definition (Specify):

Services provided to individuals unable to care for themselves when there is an absence or need for relief of those persons normally providing the care. Respite services will be furnished on a short-term basis in a nursing facility or assisted care living facility, not to exceed nine (9) days per waiver year. The intent of Respite is to provide short-term relief for caregiver vacations and emergency situations that may involve the temporary loss of a caregiver (e.g. hospitalization, illness of another relative).

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

\_\_\_ Individual's home or place of residence

\_\_\_ Foster home

\_\_\_ Medicaid certified Hospital

X Medicaid certified NF

\_\_\_ Medicaid certified ICF/MR

\_\_\_ Group home

\_\_\_ Licensed respite care facility

X Other community care residential facility approved by the State that is not a private residence (Specify type):

Assisted Living Facility

f. \_\_\_ Adult day health:

\_\_\_ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the

individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.  Yes                      2.  No

Other service definition (Specify):

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Qualifications of the providers of adult day health services are contained in Appendix B-2.

g.  Habilitation:

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

— Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

— Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

— Individuals will not be compensated for prevocational services.

— When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

— Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

— Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.  Yes                      2.  No

\_\_\_\_\_ Other service definition (Specify):  
\_\_\_\_\_  
\_\_\_\_\_

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h.  ~~Environmental accessibility adaptations~~ Minor Home Modifications:

— Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

X Other service definition (Specify):

Minor Home Modifications - the provision and installation of certain home mobility aides (e.g., ramps, rails, non-skid surfacing, grab bars, and other devices and minor home modifications which facilitate mobility) and modifications to the home environment to enhance safety. Excluded are those adaptations or improvements to the home which are of general utility and which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

I. — Skilled nursing:

— Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

— Other service definition (Specify):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

j. — Transportation:

— Service offered in order to enable individuals served in the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation

services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

\_\_\_\_ Other service definition (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

k. \_\_\_\_ Specialized Medical Equipment and Supplies:

\_\_\_\_ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

\_\_\_\_ Other service definition (Specify):  
\_\_\_\_\_

l. \_\_\_\_ Chore services:

\_\_\_\_ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

\_\_\_\_ Other service definition (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

m.   X   Personal Emergency Response Systems (PERS)

       PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

  X   Other service definition (Specify):

Personal Emergency Response Systems (PERS) - PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

n.        Adult companion services:

       Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

       Other service definition (Specify):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

o.        Private duty nursing:

       Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

\_\_\_ Other service definition (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

p. \_\_\_ Family training:

\_\_\_ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

\_\_\_ Other service definition (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

q. \_\_\_ Attendant care services:

\_\_\_ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.  
Supervision (Check all that apply):

\_\_\_ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

\_\_\_ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

\_\_\_ Other supervisory arrangements (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Other service definition (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

r. \_\_\_ Adult Residential Care (Check all that apply):

\_\_\_ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed \_\_\_\_\_. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

\_\_\_ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and

distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- Home health care
- Physical therapy
- Occupational therapy
- Speech therapy
- Medication administration
- Intermittent skilled nursing services
- Transportation specified in the plan of care
- Periodic nursing evaluations
- Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

Other service definition (Specify):

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Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

- s.  Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

Home Delivered Meals - nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the Individual Plan of Care when ordered by the Enrollee's physician.

- t.  Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- Physician services  
 Home health care services  
 Physical therapy services  
 Occupational therapy services  
 Speech, hearing and language services  
 Prescribed drugs  
 Other State plan services (Specify):

\_\_\_\_\_  
\_\_\_\_\_

- u.  Services for individuals with chronic mental illness, consisting of (Check one):

- Day treatment or other partial hospitalization services (Check one):

Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

\_\_\_\_\_ Other service definition (Specify):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ Psychosocial rehabilitation services (Check one):

\_\_\_\_\_ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking,

nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

\_\_\_ Other service definition (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

\_\_\_ This service is furnished only on the premises of a clinic.

\_\_\_ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):  
\_\_\_\_\_  
\_\_\_\_\_

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirement for the provision of each service under the waiver. Licensure, Regulation, State Administration Code are referenced by citation. Standards not addressed under Uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Case Management	Home Health Agency  Service Agency	Rule 1200-8-8.01 Minimum Standards and Regulations for Home Health Agencies  Business License		ALA Quality Assurance/Enhancement Guidelines; Approval by the ALA based on written provider qualification standards.
Personal Care Services	Home Health Agency  Service Agency	Rule 1200-8-8.01 Minimum Standards and Regulations for Home Health Agencies  Business License		ALA Quality Assurance/Enhancement Guidelines; Approval by the ALA based on written provider qualification standards

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Respite	Nursing Facility	Rule 1200-8-6 (Standards for Nursing Homes)		ALA Quality Assurance/Enhancement Guidelines; Approval by the ALA based on written provider qualification standards
	Assisted-Care Living Facility	Rule 1200-8-25 (Standards for Assisted-Care Living Facilities)		
Homemaker Services	Home Health Agency  Service Agency	Rule 1200-8-8.01 Minimum Standards and Regulations for Home Health Agencies  Business License		ALA Quality Assurance/Enhancement Guidelines; Approval by the ALA based on written provider qualification standards
Personal Emergency Response System (PERS)	Service Agency	Business License		ALA Quality Assurance/Enhancement Guidelines; Approval by the ALA based on written provider qualification standards

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Home Delivered Meals	Service Agency	Business License		ALA Quality Assurance/Enhancement Guidelines; Approval by the ALA based on written provider qualification standards; Compliance with S-3030e Subpart II "Home Delivered Nutrition Services" of the Older American Act
Minor Home Modifications	Service Agency Building Supplier, Local Contractor, Carpenter, or Craftsman Durable Medical Equipment Supplier	Business License		ALA Quality Assurance/Enhancement Guidelines; Compliance with state and local fire and safety codes; Compliance with U. S. Housing and Human Development Guidelines; Compliance with Access to Handicapped Act of 1973; Approval by the ALA based on written provider qualification standards

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

All providers shall be at least 18 years of age. Providers who have responsibility for transporting enrollees shall have a valid driver's license, shall maintain an acceptable level of automobile liability insurance, and shall have a safe driving record. Providers shall not have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act.

Provider qualification standards shall be subject to prior approval by the Bureau of TennCare. Any provider category which is not required to meet state licensure standards shall meet written ALA provider qualification standards.

## **Case Management**

A case manager shall provide to eligible Waiver recipients comprehensive in-home assessments, ongoing case management services, accurate and timely required program documentation, and coordination of Medicaid covered services and community resources. The Case Manager shall develop, implement, and review Individual Care Plans for each waiver recipient in accordance with waiver guidelines. If a Social Worker Case Manager is utilized, an in-home visit and review of the Plan of Care must be done by a Registered Nurse at least every 90 days.

A Case Manager must meet one of the following qualifications:

1) Nurse Case Manager

The Nurse Case Manager must be a Registered Nurse with a current license in the State of Tennessee and have two years nursing experience, preferably in geriatrics or home health nursing.

OR

The Nurse Case Manager must be a Licensed Practical Nurse with a current license in the State of Tennessee and two years nursing experience (preferably in geriatrics or home health nursing), working under the supervision of a Registered Nurse.

2) Social Worker Case Manager

The Social Worker Case Manager must have a Master's Degree in Social Work, Psychology, Sociology, or a related field from an accredited college or university and one year of supervised social services experience, with experience in geriatrics or service planning and delivery for the disabled preferred.

OR

The Social Worker Case Manager must have a Bachelor's Degree in Social Work, Psychology, Sociology, or other field related to social work and must have two years of supervised work experience in a social services program, with experience in geriatric or service planning and delivery for the disabled preferred. The Bachelor's level Social Worker must work under the supervision of a Social Worker with a Master's Degree or a Registered Nurse.

## **Personal Care Services**

Persons who are providers of Personal Care Services must have a good knowledge of basic living skills and of Basic English sufficient to read and understand instructions, to prepare and maintain written reports and records, and to communicate with the individual. The provider must possess the ability to provide personal care services. The person must not be listed in the Tennessee Nurse Aide Abuse Registry as being barred from being employed as a nurse aide due to patient abuse.

## **Respite**

Persons who are Respite Care Providers must have a good knowledge of basic living skills, good knowledge of Basic English, sufficient to learn to write reports, keep records, and read instructions. The provider must possess the ability to provide residential care, and the ability to prepare a variety of routine records and reports.

The provider must be at least 18 years of age.

## **Homemaker Services**

Persons who are providers of Homemaker Services must have a good knowledge of basic living skills and of Basic English sufficient to read and understand instructions, to prepare and maintain written reports and records, and to communicate with the individual. The provider must possess the ability to provide homemaker services. The person must not be listed in the Tennessee Nurse Aide Abuse Registry as being barred from being employed as a nurse aide due to patient abuse.

## **Home Delivered Meals**

The provider of Home Delivered Meals shall supply meals from premises which are properly licensed or certified by the appropriate regulatory authority and will comply with all laws, ordinances, and codes regarding preparation, handling, and delivery of food. The meal will provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences, National Research Council). Special diets will be provided, if ordered by the physician.

Providers will comply with Section 3030e Subpart II "Home Delivered Nutrition Services" of the Older Americans Act and with the following provisions:

- 1) Food must be packed in an insulated transport chest.
- 2) Food must be transported in heated containers. Hot foods must be served at 140 degrees and above, and cold foods must be served at 45 degrees and below.
- 3) Meals must be served within one hour after they leave distribution point.
- 4) Each meal must meet 1/3 of the RDA.
- 5) The Dietitian must provide meal plans and monitor for compliance to the meal plan, including periodic onsite observation of meal preparation. A dietician must be on staff at the distribution site.
- 6) Both the kitchen and the distribution site must be inspected by the local Tennessee Department of Health and meet applicable guidelines.

## **Personal Emergency Response Systems (PERS)**

The monitoring center shall be staffed twenty-four hours a day, 365 days a year. There shall be a trained monitor on call at all times to assist during staff shortages. There shall be sufficient staff to assure a fast emergency response capability, i.e. within one (1) to two (2) minutes.

Training Requirements for Monitoring Staff shall include the following:

- 1) Each employee utilized to handle personal emergency response calls must receive initial training in the following areas:
  - a) Response procedures and protocol
  - b) Use and care of the equipment (both in-home and in the response center)
  - c) Alarm and Communication Logging Procedures
  - d) Response Center System Test Procedures
  - e) Customer Service and Telephone Skill
  - f) Geriatric Issues
  - g) Computer Skills, if applicable
- 2) Duties of all PERS (Personal Emergency Response System) staff must be clearly defined in written job descriptions.
- 3) Initial on-location training must be provided to response center staff before they assume normal job responsibilities. This shall include training on all operational aspects of the PERS, including installation and testing of equipment and program implementation.
- 4) Documented evidence of employee training (both initial and annually thereafter), must be made available to any state or federal auditors who are conducting a program audit or review. Training must consist of on the job experience in the presence of trained and experienced monitoring personnel. In-service training for PERS staff must be regularly scheduled. It shall total a minimum of six hours per year and shall be documented in staff personnel records as to content, date and duration.
- 5) The PERS staff shall have written procedures for dealing with emergencies of clients and all PERS staff who provide direct services shall have initial and ongoing training in these emergency procedures. The procedures shall cover immediate care of the client, ambulance to be called, name(s) and phone numbers of physician(s), the client's preference of hospitals, a listing of any known drug allergies, any other pertinent medical information deemed critical to the care of the client in an emergency, and persons to be notified. There should also be training on reports to be prepared.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

\_\_\_\_\_ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

  X   A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

## APPENDIX C-Eligibility and Post-Eligibility

### Appendix C-1--Eligibility

#### MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.  AFDC recipients
2.  SSI recipients (SSI Rules States & 1634 States).
3.  Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4.  Optional State supplement recipients
5.  Optional categorically needy aged and disabled who have income at (Check one):
  - a.  100% of the Federal poverty level (FPL)
  - b.  % Percent of FPL which is lower than 100%.
6.  The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Check one:

  - a.  The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or
  - b.  Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

- (1) X A special income level equal to:
- X 300% of the SSI Federal benefit (FBR)
  - \_\_\_% of FBR, which is lower than 300% (42 CFR 435.236)
  - \$ \_\_\_ which is lower than 300%
- (2) \_\_\_ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)
- (3) \_\_\_ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)
- (4) \_\_\_ Medically needy without spend down in 209(b) States. (42 CFR 435.330)
- (5) \_\_\_ Aged and disabled who have income at:
- a. \_\_\_ 100% of the FPL
  - b. \_\_\_% which is lower than 100%.
- (6) \_\_\_ All other mandatory and optional groups under the plan are included.
- (7) \_\_\_ Other (Include statutory reference only to reflect additional groups included under the State plan.)
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Spousal impoverishment rules are used in determining eligibility for this special home and community-based waiver group at 42 CFR 435.217.

7. X Medically needy (42 CFR 435.320, 435.322, 435.324 and ~~435.330~~)
8. \_\_\_ All other mandatory and optional groups under the plan are included.
9. \_\_\_ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

## Appendix C-2--Post-Eligibility

### GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic re-determination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and needed home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options with regard to the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

### REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC eligibility standard for a family of the same size or

by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

#### **SPOUSAL POST-ELIGIBILITY--§1924**

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance "which is reasonable in amount for clothes and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month, but must be a reasonable amount for clothing and other personal needs of an individual while in an institution. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. Therefore, the \$30 PNA may not be a reasonable amount when the waiver recipient is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal rule may use as the personal needs allowance the maintenance amount which the State has elected for home and community-based services waiver participants who do not have community spouses.

NOTE: If the State elects to use the institutional PNA, it must demonstrate that this is a reasonable amount to cover the cost of the individual's maintenance needs in the community (see OPTION 2).

**POST ELIGIBILITY**

**REGULAR POST ELIGIBILITY**

1.  X  **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A.  § 435.726 --States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.  X  The following standard included under the State plan (check one):

(1)   SSI

(2)   Medically needy

(3)   The special income level for the Institutionalized

(4)   The following percent of the Federal poverty level):  
 %

(5)  X  Other (specify):

200% of the SSI-FBR

B.   The following dollar amount:  
 \$  \*

\* If this amount changes, this item will be revised.

C.   The following formula is used to determine the needs allowance:

**Note:** If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have

and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.**  
following.

2. spouse only (check one):

A. \_\_\_ SSI standard

B. \_\_\_ Optional State supplement standard

C. \_\_\_ Medically needy income standard

D. \_\_\_ The following dollar amount:  
\$ \_\_\_\_\_\*

\*If this amount changes, this item will be revised.

E. \_\_\_ The following percentage of the following standard  
that is not greater than the standards above: \_\_\_\_\_%  
of  
standard.

F. X The amount is determined using the following  
formula:

Spousal impoverishment post-eligibility rules are  
used

G. \_\_\_ Not applicable (N/A)

3. Family (check one):

A. \_\_\_ AFDC need standard

B. \_\_\_ AFDC payment standard

C. X Medically needy income standard

D. \_\_\_ The following dollar amount:  
\$ \_\_\_\_\_\*

\*If this amount changes, this item will be revised.

E. \_\_\_ The following percentage of the following standard  
that is not greater than the standards above: \_\_\_\_\_%  
of \_\_\_\_\_ standard.

F. \_\_\_ The amount is determined using the following  
formula

\_\_\_\_\_

---

G.\_\_\_\_ Not applicable (N/A)

- b. Medical and remedial care expenses specified in 42 CFR 435.726.

**POST-ELIGIBILITY**

**REGULAR POST ELIGIBILITY**

1.(b) N/A **209(b) State, a State that is using more restrictive eligibility requirements than SSI.**  
The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

(1) individual: (check one):

A. \_\_\_ The following standard included under the State plan  
(check one):

(1) \_\_\_ SSI

(2) \_\_\_ Medically needy

(3) \_\_\_ The special income level for the  
institutionalized

(4) \_\_\_ The following percentage of the  
Federal poverty level: \_\_\_%

(5) \_\_\_ Other (specify):

\_\_\_\_\_

\_\_\_\_\_

B. \_\_\_ The following dollar amount:

\$ \_\_\_\*

\* If this amount changes, this item will be revised.

C. \_\_\_ The following formula is used to determine the amount:

\_\_\_\_\_

\_\_\_\_\_

**Note:** If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. \_\_\_ The following standard under 42 CFR 435.121: \_\_\_

B. \_\_\_ The medically needy income standard \_\_\_\_\_;

C. \_\_\_ The following dollar amount:  
\$ \_\_\_\_\_\*

\*If this amount changes, this item will be revised.

D. \_\_\_ The following percentage of the following standard that is not greater than the standards above:  
\_\_\_\_\_ % of \_\_\_\_\_

E. \_\_\_ The following formula is used to determine the amount:  
\_\_\_\_\_  
\_\_\_\_\_

F. \_\_\_ Not applicable (N/A)

3. family (check one):

A. \_\_\_ AFDC need standard

B. \_\_\_ AFDC payment standard

C. \_\_\_ Medically needy income standard

D. \_\_\_ The following dollar amount:  
\$ \_\_\_\_\_\*

\*If this amount changes, this item will be revised.

E. \_\_\_ The following percentage of the following standard that is not greater than the standards above:  
\_\_\_\_\_ % of \_\_\_\_\_ standard.

F. \_\_\_ The following formula is used to determine the amount:  
\_\_\_\_\_  
\_\_\_\_\_

G. \_\_\_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

**POST ELIGIBILITY**

**SPOUSAL POST ELIGIBILITY**

2. X The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the spouses monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(1)  Institutional PNA: Specify the amount: \$      \*

\*Explain why you believe this amount is reasonable to meet the maintenance need of the individual in the community:

\_\_\_\_\_

\_\_\_\_\_

(2) X An amount which is comparable to the amount used as the maintenance allowance of the individual for home and community based waiver recipients who have no community spouses. (check one):

(a)  SSI Standard

(b)  Medically Needy Standard

(c)  The special income level for the institutionalized

(d)  The following percent of the Federal poverty level:      %

(e) X Other (specify):

200% of the SSI-FBR

\_\_\_\_\_

(f)  The following dollar amount \$      \*\*

\*\*If this amount changes, this item will be revised.

(g)  The following formula is used to determine the needs allowance:

\_\_\_\_\_

\_\_\_\_\_

APPENDIX D  
ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

Discharge planning team

Physician (M.D. or D.O.)

Registered Nurse, licensed in the State

Licensed Social Worker

Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

Other (Specify):

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---

---

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

Every 3 months

Every 6 months

Every 12 months

Other (Specify):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

Physician (M.D. or D.O.)

Registered Nurse, licensed in the State

Licensed Social Worker

Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

Other (Specify):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

- "Tickler" file
- Edits in computer system
- Component part of case management
- Other (Specify):

---

---

---

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

- By the Medicaid agency in its central office (Initial Evaluation)
- By the Medicaid agency in district/local offices
- By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
- By the case managers
- By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
- By service providers
- Other (Specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

- The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.
- The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
  - a. informed of any feasible alternatives under the waiver; and
  - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
  - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
  - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
  - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
  - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

In the enrollee's medical record with enrollment papers at the Area Agency on Aging.

**PREADMISSION EVALUATION FOR NURSING FACILITY CARE**

\*\*\*\*\*

<< To be completed by TennCare >>

**APPROVAL**

<u>DECISION</u>	<u>LEVEL</u>	<u>APPROVAL DATE</u>	<u>END DATE</u>	<u>REVIEWER</u>	<u>REVIEW DATE</u>
YES NO	1 2 H P	_____	-- _____	_____	_____
YES NO	1 2 H P	_____	-- _____	_____	_____
YES NO	1 2 H P	_____	-- _____	_____	_____
YES NO	1 2 H P	_____	-- _____	_____	_____

<< NOTE: This PAE must be used within 90 days of the "APPROVAL DATE". >>

\*\*\*\*\*

**SERVICE REQUESTED \***

\* **PROVIDER** Name \_\_\_\_\_

[ ] Level 1 \* \_\_\_\_\_

[ ] Level 2 \* \_\_\_\_\_

[ ] HCBS Waiver \* \_\_\_\_\_

[ ] PACE Program \* \_\_\_\_\_

\*\*\*\*\*

Provider Number \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**PATIENT**

**Name** \_\_\_\_\_  
(Last) (First) (Middle)

Street Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

Medicaid Number \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**DESIGNEE**

**Name** \_\_\_\_\_  
(Last) (First) (Middle)

Street Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

I certify that I do NOT want a designated correspondent. \_\_\_\_\_  
Signature

**ADMISSION**

- [ ] New admission – admitted from home, hospital, or another Nursing Facility
- [ ] Readmission after discharge for hospitalization
- [ ] New Medicaid Eligible – had been private pay or had other payor
- [ ] Former Medicaid Eligible – now Medicaid Eligible after being private pay
- [ ] Expiration of PAE
- [ ] Change in level of reimbursement
- [ ] Other (specify): \_\_\_\_\_

\*\*\*\*\*

Send To: TennCare Long-Term Care Division: \*

By FAX: (615) 741-9260 \*

By U.S. Mail: P.O. Box 450, Nashville, TN 37202-0450 \*

By Other Delivery: 729 Church Street, Nashville, TN 37247-6501 \*



PATIENT'S NAME \_\_\_\_\_

**CAPABILITIES** (Circle one answer: A = Always; U = Usually; UN = Usually Not; N = Never)

**TRANSFER**      A   U   UN   N      Can patient transfer without physical help from others?  
# days/week physical assistance is required \_\_\_\_\_

**MOBILITY**      A   U   UN   N      Can patient walk without physical help from others?  
# days/week physical assistance is required \_\_\_\_\_

                  A   U   UN   N      Can patient use a wheelchair without physical help from others?  
# days/week physical assistance is required \_\_\_\_\_

**EATING**      A   U   UN   N      **Can patient place food/drink in the mouth without physical help from others?**  
# days/week physical assistance is required \_\_\_\_\_

**TOILETING**    A   U   UN   N      Can patient use a toilet without physical help from others?  
# days/week physical assistance is required \_\_\_\_\_

                  A   U   UN   N      IF INCONTINENT, can patient do incontinence care without physical help from others?  
# days/week physical assistance is required \_\_\_\_\_

                  A   U   UN   N      INDWELLING CATHETER or OSTOMY if present: Can patient do self-care without  
physical help from others?  
# days/week physical assistance is required \_\_\_\_\_

**COMMUNICATION**    A   U   UN   N      Can patient express basic needs and wants (e.g., assistance with toileting; presence of  
pain) ?  
# days/week problem occurs \_\_\_\_\_

                  A   U   UN   N      Can patient understand and follow very simple instructions (i.e., how to perform basic  
activities of daily living) without continual staff intervention?  
# days/week problem occurs \_\_\_\_\_

**ORIENTATION**    A   U   UN   N      Is patient oriented to person (remembers name; recognizes family) and  
place (knows is in nursing facility)?  
# days/week problem occurs \_\_\_\_\_

**MEDICATIONS**    A   U   UN   N      Can patient self-administer medications with limited help from others\_ (e.g. reminding,  
encouragement, reading labels, opening bottles, handing to patient, reassurance of  
dose)?

# days/week problem occurs \_\_\_\_\_

                  A   U   UN   N      Insulin patients only: If on a fixed dose, can patient inject insulin with a pre-filled  
syringe or if on sliding scale, can patient draw up and inject insulin?

# days/week problem occurs \_\_\_\_\_

**BEHAVIOR**      A   U   UN   N      Does patient require continual staff intervention for a persistent pattern of dementia-  
related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive  
elopement) ?

# days/week intervention is required \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

**NURSING & REHABILITATIVE SERVICES:** Check all that apply and indicate frequency.

- Catheter care, indwelling ..... X daily or \_\_\_\_\_ X weekly
- Dressings, sterile, Stage 3 or 4 decubiti..... X daily or \_\_\_\_\_ X weekly
- Dressings, sterile, multiple Stage 2 decubiti..... X daily or \_\_\_\_\_ X weekly
- Dressings, sterile, other..... X daily or \_\_\_\_\_ X weekly
- Injections, fixed-dose insulin..... X daily or \_\_\_\_\_ X weekly
- Injections, sliding scale insulin..... X daily or \_\_\_\_\_ X weekly
- Injections, other: IV, IM, subQ..... X daily or \_\_\_\_\_ X weekly
- Intravenous fluid administration..... X daily or \_\_\_\_\_ X weekly
- Isolation precautions..... X daily or \_\_\_\_\_ X weekly
- Occupational therapy by OT or OT assistant..... X daily or \_\_\_\_\_ X weekly
- Ostomy Care..... X daily or \_\_\_\_\_ X weekly
- Oxygen administration, stationary system..... X daily or \_\_\_\_\_ X weekly
- Physical therapy by PT or PT assistant..... X daily or \_\_\_\_\_ X weekly
- Respiratory therapy by RT, RT asst., or nurse..... X daily or \_\_\_\_\_ X weekly
- Suctioning, tracheal/tracheostomy..... X daily or \_\_\_\_\_ X weekly
- Teaching catheter/ostomy care..... X daily or \_\_\_\_\_ X weekly
- Teaching self-injection..... X daily or \_\_\_\_\_ X weekly
- Total parenteral nutrition..... X daily or \_\_\_\_\_ X weekly
- Tube feeding, gastrostomy or nasogastric..... X daily or \_\_\_\_\_ X weekly
- Ventilator services..... X daily or \_\_\_\_\_ X weekly
- Other:..... X daily or \_\_\_\_\_ X weekly
- Other:..... X daily or \_\_\_\_\_ X weekly
- Other:..... X daily or \_\_\_\_\_ X weekly

**LEVEL 2 REQUESTS only:** Indicate the daily skilled nursing or rehabilitative service for which Level 2 reimbursement is requested.

\_\_\_\_\_

**AGGRESSIVE BEHAVIOR:** Circle yes or no.

**YES NO** Does the individual have an established and persistent pattern of aggressive behavior that has endangered the health or safety of others? If yes, attach a statement that describes such pattern of behavior and outlines specific care needs for the individual to ensure the health and safety of others.

I certify that the above information is accurate for the requested date of service.

Signature of physician, nurse, or PA \_\_\_\_\_ Date \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

PHYSICIAN'S CERTIFICATION OF NURSING FACILITY CARE

DIAGNOSES Primary \_\_\_\_\_  
Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROGNOSIS \_\_\_\_\_

ATTACHMENTS (Please submit the following attachments.)

1. Recent history and physical: A history and physical done within the past 12 months may be used if accompanied by a physician's statement indicating that the patient's condition has not significantly changed.
2. Physician orders, including current medications.

PAE REQUEST DATE for Medicaid-reimbursed nursing facility care: \_\_\_\_\_

CERTIFICATION

I certify that the requested level of Nursing Facility care (or Waiver services or PACE program alternatives) is medically necessary for this patient.

Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

\*\*\*\*\*

<< Complete the following section only if the PAE Request Date must be revised. >>

\*\*\*\*\*

CERTIFICATION UPDATE

I certify that the patient's medical condition on the revised PAE Request Date is consistent with that described in the initial certification and that Nursing Facility care is medically necessary for the patient.

<u>Revised PAE Request Date</u>	<u>Signature of Physician</u>	<u>Date of Signature</u>
_____	_____	_____
_____	_____	_____

**PASARR LEVEL I ASSESSMENT FOR MENTAL ILLNESS & MENTAL RETARDATION**

**MENTAL ILLNESS** (Circle yes or no.)

YES NO Does the individual have a diagnosis of a major MENTAL ILLNESS (e.g., schizophrenia, paranoid state, bipolar disorder, atypical psychosis, major depression)? If so, indicate diagnosis. \_\_\_\_\_

YES NO Does the individual have any presenting evidence of MENTAL ILLNESS, including disturbances in orientation, affect, or mood? Exclude individuals who have a primary diagnosis of dementia (including Alzheimer's disease and related disorders), and exclude individuals who have a secondary diagnosis of dementia (including Alzheimer's disease and related disorders) and who do not have a primary diagnosis of a major mental illness.

YES NO Has the individual had a history of MENTAL ILLNESS in the last 2 years?

**MENTAL RETARDATION** (Circle yes or no.)

YES NO Does the individual have a diagnosis of MENTAL RETARDATION?

YES NO Does the individual have any presenting evidence (cognitive or behavior functions) that suggests that the individual has MENTAL RETARDATION or DEVELOPMENTAL DISABILITIES, and has the individual been deemed eligible for services of such an agency? If so, which agency. \_\_\_\_\_

YES NO Does the individual have any history of MENTAL RETARDATION or DEVELOPMENTAL DISABILITY that was manifested before age 22?

YES NO Has the individual been referred by an agency that serves persons with MENTAL RETARDATION or DEVELOPMENTAL DISABILITIES, and has the individual been deemed eligible for services of such an agency? If so, which agency. \_\_\_\_\_

I certify that the above information is accurate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

**EXEMPTIONS** (Complete this section only if Level I PASARR indicates mental illness or mental retardation and if there is an applicable exemption.)

I certify that the individual is exempt from the PASARR Level II assessment because of:

[ ] **DEMENTIA:** The individual has a primary diagnosis of dementia (including Alzheimer's disease and related disorders) based on neurological examination; or the individual has a secondary diagnosis of dementia (including Alzheimer's disease and related disorders) based on neurological examination and does not have a primary diagnosis of a major mental illness. Dementia is NOT ALLOWED as an exemption if the individual has, or is suspected of having, a diagnosis of mental retardation.

[ ] **TERMINAL ILLNESS:** The individual is terminally ill, has a medical prognosis that life expectancy will be 6 months or less, and is not a danger to self or others.

[ ] **SHORT-TERM CONVALESCENCE:** The individual is being admitted from a hospital for convalescent care not to exceed 120 days and is not a danger to self or others.

[ ] **SEVERITY OF ILLNESS:** The individual has a medical condition of such severity that it would prohibit participation in specialized services for mental illness or mental retardation (e.g., coma, ventilator-dependent, severe COPD, severe CHF, severe Parkinson's Disease, Huntington's Disease, or Amyotrophic Lateral Sclerosis) and is not a danger to self or others. Note: Please submit medical documentation.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**FREEDOM OF CHOICE DOCUMENTATION**

I have been informed of the feasible alternatives available under the waiver and have been given the choice of either institutional care or home and community based waiver services. I also understand that I have the right to request a fair hearing under 42 CFR Part 431, Subpart E when not given the choice of home and community based services as an alternative to institutional care or have been denied the service(s) of my choice or the provider of my choice.

\_\_\_\_\_Home and Community Based Services      \_\_\_\_\_Institutional Services

\_\_\_\_\_

Patient and Designated Representative

Witness

\_\_\_\_\_

Date

ATTACHMENT TO APPENDIX D-4

Procedures for informing individuals of alternatives and allowing choice:

1. The TennCare Bureau sends a letter to all individuals approved for nursing facility level of care. This letter advises the individual of the Waiver as an alternative to nursing facility admission. Potential waiver enrollees who mark "Yes" on the letter and return it in a stamped self-addressed envelope to the Bureau of TennCare are referred to the contract agency for further screening.
2. The contract agency screens all referrals from all sources, including those referred by TennCare, for potential eligibility for the Waiver. Part of this screening process is to advise the individual or family member, etc. acting on behalf of the individual, of the waiver as an alternative to nursing facility admission.
3. The contract agency visits all potentially eligible individuals, either in their home or in a facility, and prepares an assessment of the individual's needs. Again, at the time of the visit, the waiver, as an alternative to nursing home admission, is explained to the individual and/or family member(s).

A "Freedom of Choice" form is signed by the patient or designated representative, etc. acting on behalf of the individual, if the individual is unable to sign due to physical and/or mental limitations. This form indicates their choice of either the Waiver or nursing facility admission.



Bureau of TennCare  
Division of Long Term Care

Subject: HCBS Waiver Appeals Procedures	
Date: November 10, 2000	
Approval:	Date:

**POLICY/PURPOSE:**

To ensure that waiver applicants and enrollees are properly notified of and allowed access to due process appeals rights. To ensure compliance with the Grier Consent Decree and related state public necessity rules.

**PROCEDURE:**

**Standard Waiver Appeals Procedures**

All persons receiving Medicaid Waiver services shall be provided a plain language explanation of appeal rights upon enrollment in the Waiver Program. If the enrollee has limited English proficiency, competent oral translation of written material in the primary language of the enrollee will be provided at no cost to the enrollee.

The Administrative Lead Agency (ALA) has up to 21 days to approve or deny a request for waiver services. If the ALA does not respond with the 21 days following the request for services, the services are deemed authorized. When requests for Medicaid Waiver services are approved, notice of the approval of the requested services must be provided within 5 calendar days of the request. The service must be provided within 5 calendars of the request for service unless there is evidence of good cause why the services cannot be provided within 5 calendar days. (Good Cause may be determined on a case by case basis.) The ALA must notify the TennCare Solutions Unit prior to the expiration of the 5 calendar days of an anticipated delay and the basis for the delay.

The ALA must provide a plain language written notice and must set out the appeal rights when any adverse action results in delay, denial, termination, suspension or reduction of waiver services to any person receiving Medicaid Waiver services. Plain language written notice must also be provided when any other act or omission by the ALA may impair the quality, timeliness or availability of Waiver services. The notice must be received by the person receiving waiver services 10 calendar days prior to the date of the proposed adverse action.

Any person who has requested Medicaid Waiver services and receives notice of a proposed adverse action has the right to appeal the adverse action and to request a hearing. A request for a hearing shall be submitted in writing to the TennCare Solutions Unit no later than 30 calendar days after receipt of the notice of the proposed adverse action.

Any person receiving Medicaid Waiver services who receives a notice of proposed adverse action has 10 calendar days or 5 calendar days (as applicable under 42 CFR 431.213 and 214) after receipt of the Notice to request the continuation of Waiver services. Those services may continue until an initial hearing decision. If the

decision of the ALA is upheld at the hearing, recovery procedures may be instituted to recoup the cost of any waiver services furnished solely as a result of the continuation of service during the appeal process.

After the TennCare Solutions Unit receives a request for an appeal, the ALA will have 14 calendar days to perform a reconsideration review and the ALA shall notify the individual or their designee if the ALA approves the services upon reconsideration. The ALA shall notify the TennCare Solutions Unit if the ALA denies services upon reconsideration and the TennCare Solutions Unit shall review the initial service request. If after review, the TennCare Solutions Unit approves the services, the unit shall inform the ALA of the decision. The TennCare Solutions Unit shall provide a written notice to the ALA authorizing the requested service and a written notice shall be provided to the person requesting the Medicaid Waiver services within 5 calendar days. The ALA must provide the services within 5 calendar days unless good cause is shown that the services cannot be provided within 5 calendar days.

After a review of the initial request for services, if the services are denied and the proposed adverse action is upheld by the TennCare Solutions Unit, the person requesting to receive the Medicaid Waiver services has the right to an appeal. Reasonable accommodations shall be made for persons who require assistance with the appeal process.

All hearings shall be held pursuant to the provisions of the Tennessee Uniform Administrative Procedures Act and shall be held before an impartial hearing officer or Administrative Law Judge. The administrative hearing may be conducted by telephone or in person.

The enrollee has 15 days from notification of the initial order to appeal the decision of the Administrative Law Judge. If there is no appeal of the initial order, it becomes a final order. The ALA cannot appeal the Administrative Law Judge decision. The appeal is to a court of competent jurisdiction.

The hearing decision shall be issued within 90 calendar days from the date the appeal is received. In some circumstances, if the hearing decision is not issued by the 90th day, the waiver services may be provided until an order is issued.

## **Time Sensitive Appeals**

In situations where Time Sensitive (urgent) medical care is necessary, an expedited appeal may be requested. Once the TennCare Solutions Unit receives a Time Sensitive appeal request, the ALA must review for reconsideration of the request within 5 calendar days of receiving the request. If the service is approved, the TennCare Solutions Unit is notified and written notice of the authorization is sent to the enrollee within 5 days. When the service is denied, the individual is offered an Administrative Hearing. Within 31 days of the appeal request, a decision must be provided.

### **NECESSARY FORMS:**

None

### **REFERENCE DOCUMENTS:**

- 42 CFR 431.213 and 214
- Revised Grier Consent Decree 7/31/2000 (Civil Action Number 79-3107, U.S. District Court for Middle District of Tennessee, Nashville Division)
- State public Necessity Rules 1200-13-12-.11

**OFFICE OF PRIMARY RESPONSIBILITY:**

TennCare Division of Long Term Care

**APPENDIX E - PLAN OF CARE**

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Physician (M.D. or D.O.) licensed to practice in the State
- Social Worker (qualifications attached to this Appendix)
- Case Manager
- Other (specify):  
\_\_\_\_\_  
\_\_\_\_\_

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

- At the Medicaid agency central office (Initial)
- At the Medicaid agency county/regional offices
- By case managers
- By the agency specified in Appendix A
- By consumers
- Other (specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

- every 3 months
- Every 6 months

Every 12 months

Other (specify):

At least every 90 days

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## APPENDIX E-2

### a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The initial plan of care is submitted to the TennCare Division of Long Term Care for review and approval by a Registered Nurse. Once approved, the Plan of Care, with an approval letter will be returned to the Administrative Lead Agency to be maintained in the individual record.

### b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

**OPTIONS FOR COMMUNITY LIVING  
SERVICE PLAN**

1. Initial ( ) Review ( )	2. Consumer Name:	3. Consumer Medical Diagnosis:
4. Physician(s):	6. Caregiver Information: (Name of each caregiver and schedule)	
5. Physician Phone No.	7. Safety Plan, if applicable: (see attached)	
8. Date Rec'd:	10. TennCare No.:	11. Social Security No:
9. Date Prepared:	12. County:	

**SERVICE PLAN**

13. Needs	14. Services Needed (frequency, amount, duration)	15. Goals	16. Any treatments, therapies, diets, adaptive equipment, etc.

Service Plan – Effective From: \_\_\_\_\_ To: \_\_\_\_\_

**SERVICE AUTHORIZED**

17. Services Authorized	18. Waiver	19. Funding Source	20. Provider	21. Frequency	22. Total Units	23. Cost per Unit	24. Weekly Cost	25. Six Month Cost	26. Date Authorized	27. Start Date	28. End Date
	Y / N										
	Y / N										
	Y / N										
	Y / N										
	Y / N										

29. Next Service Plan Review ( ) 1 Month ( ) 2 Months ( ) 3 Months ( ) Other \_\_\_\_\_ Date: \_\_\_\_\_

30. General Comments:

I have been involved in developing this service plan. I understand that it may be revised as my preferences and needs change. I have been given the option to choose providers.

31. Signature of Consumer \_\_\_\_\_ Date: \_\_\_\_\_

32. Signature of Service Coordinator \_\_\_\_\_ Date: \_\_\_\_\_

33. Authorized by AAAD \_\_\_\_\_ Date: \_\_\_\_\_

AAAD Financial Officer: \_\_\_\_\_ Date: \_\_\_\_\_

**APPENDIX F - AUDIT TRAIL**

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):

  X   Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

       Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

       Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

       Other (Describe in detail):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
  - a. When the individual was eligible for Medicaid waiver payment on the date of service;
  - b. When the service was included in the approved plan of care;
  - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

\_\_\_\_\_ Yes

X  No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

X  All claims are processed through an approved MMIS.

\_\_\_\_\_ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

\_\_\_\_\_ The Medicaid agency will make payments directly to providers of waiver services.

X  The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

\_\_\_\_\_ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

\_\_\_\_\_ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX F - Attachment to F.b.1

- a. Claims for home and community based services are submitted on a Turnaround Document. The claims go through a Medicaid MMIS where edits are applied to the specific HCBS program. Each waiver services will be assigned a unique billing code.
  1. Claims hit verification edits, duplicate edits, and provider edits in the system. Regarding claim types, cross-checking is done to make sure services billed have not been billed by another provider at a different facility. Checking verification edits is the mechanism that determines that the client was eligible for Medicaid payment on the date of service.
  2. To be admitted to the program, the recipient must have an approved Preadmission Evaluation (PAE), the initial approved plan of care that identifies services for the recipient. The PAE determines level of care and reflects the beginning eligibility date for that level of care. The approved PAE is loaded onto the system as a Level of Care (LOC) 8. Claims coming through the system are processed against the PAE as LOC 8. If claims are billed for dates-of-service for a prior period, the system will not pay. During the annual quality assurance audit, ongoing plans of care are reviewed to determine that services ordered are included in the plan of care. All ongoing plans of care are subject to Medicaid approval.
- b. All HCBS claims go through a Medicaid MMIS. The initial approved plan of care, PAE, identifies the services the recipient will receive. Claims will not be paid unless when the claim is processed, the system shows the PAE segment at a Level of Care (LOC) 8.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1  
COMPOSITE OVERVIEW  
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE:                     NF (level 1)                    

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	<u>\$ 8,581.90</u>	<u>\$ 1,787.66</u>	<u>\$ 32,838.26</u>	<u>\$ 1,495.83</u>
2	<u>\$ 8,839.36</u>	<u>\$ 1,841.29</u>	<u>\$ 33,823.41</u>	<u>\$ 1,540.70</u>
3	<u>\$ 9,104.54</u>	<u>\$ 1,896.53</u>	<u>\$ 34,838.11</u>	<u>\$ 1,586.93</u>

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	2871
2	2871
3	2871

EXPLANATION OF FACTOR C:

Check one:

X The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

\_\_\_\_\_ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2  
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: NF (level 1)

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page



APPENDIX

FACTOR D

LOC: NF (level 1)

Demonstration of Factor D estimates:

FY 2002		FY 2003		FY 2004	
1		2	X	3	

**WAIVER YEAR**

WAIVER SERVICE	TYPE OF UNIT	# UNDUP. RECIPI. (USERS)	AVG. # ANNUAL UNITS/USER	AVG. UNIT COST	TOTAL
COLUMN A		COLUMN B	COLUMN C	COLUMN D	COLUMN E
1 Case Management	30 minutes	2,871	48	\$58.35	\$8,041,027.90
2 Personal Care Services	Hour	2,153	416	\$16.67	\$14,929,264.79
3 Respite	Day	230	9	\$94.69	\$195,725.93
4 Minor Home Modifications	Year	251	1	\$437.09	\$109,802.67
5 Personal Emergency Response Systems: One-time installation	Month	603	1	\$48.09	\$28,994.30
5(a) Personal Emergency Response Systems: Monthly fee	Month	603	9	\$39.84	\$216,162.02
6 Home Delivered Meals	Meal	790	173	\$6.16	\$841,904.00
7 Homemaker	Hour	1,148	52	\$17.00	\$1,014,923.92
<b>GRAND TOTAL</b>					\$25,377,805.53
<b>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:</b>					2,871
<b>FACTOR D (divide total by number of recipients):</b>					\$8,839.36
<b>AVERAGE LENGTH OF STAY:</b>					<b>258</b>

\*Source FY98-99 HCFA 372 report for Waiver number 0062.90

(DAYS OF CARE/UNDUPLICATED RECIPIENTS)  
100,637 390

STATE: Tennessee

74

DATE:

October 1, 2001

APPENDIX

FACTOR D

LOC: NF (level 1)

Demonstration of Factor D estimates:

FY 2002		FY 2003		FY 2004	
1		2		3	X

**WAIVER YEAR**

WAIVER SERVICE	TYPE OF UNIT	# UNDUP. RECIPI. (USERS)	AVG. # ANNUAL UNITS/USER	AVG. UNIT COST	TOTAL
COLUMN A		COLUMN B	COLUMN C	COLUMN D	COLUMN E
1 Case Management	30 minutes	2,871	48	\$60.10	\$8,282,258.73
2 Personal Care Services	Hour	2,153	416	\$17.17	\$15,377,142.74
3 Respite	Day	230	9	\$97.53	\$201,597.71
4 Minor Home Modifications	Year	251	1	\$450.20	\$113,096.75
5 Personal Emergency Response Systems: One-time installation	Month	603	1	\$49.53	\$29,864.13
5(a) Personal Emergency Response Systems: Monthly fee	Month	603	9	\$41.03	\$222,646.88
6 Home Delivered Meals	Meal	790	173	\$6.35	\$867,161.12
7 Homemaker	Hour	1,148	52	\$17.51	\$1,045,371.64
<b>GRAND TOTAL</b>					\$26,139,139.69
<b>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:</b>					2,871
<b>FACTOR D (divide total by number of recipients):</b>					\$9,104.54
<b>AVERAGE LENGTH OF STAY:</b>					<b>258</b>

\*Source FY98-99 HCFA 372 report for Waiver number 0062.90

(DAYS OF CARE/UNDUPLICATED RECIPIENTS)  
100,637 390

STATE: Tennessee

75

DATE:

October 1, 2001

APPENDIX G-3  
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care\*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

\*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: NF (level 1)

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: NF (level 1)

Factor D' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for years 98-99 of waiver  
# 0062, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

APPENDIX G-6

FACTOR G

LOC: NF (level 1)

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

- Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- Based on trends shown by HCFA Form 372 for years 98-99 of waiver # 0062, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.
- Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.
- Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: NF (level 1)

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: NF (level 1)

Factor G' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for years 98-99 of waiver  
# 0062, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: NF (level 1)

YEAR 1

FACTOR D:	\$ 8,581.90	FACTOR G:	\$ 32,838.26
FACTOR D':	\$ 1,787.66	FACTOR G':	\$ 1,495.83
TOTAL	\$ 10,369.56	TOTAL	\$ 34,334.09

YEAR 2

FACTOR D:	\$ 8,839.36	FACTOR G:	\$ 33,823.41
FACTOR D':	\$ 1,841.29	FACTOR G':	\$ 1,540.70
TOTAL	\$ 10,680.65	TOTAL	\$ 35,364.11

YEAR 3

FACTOR D:	\$ 9,104.54	FACTOR G:	\$ 34,838.11
FACTOR D':	\$ 1,896.53	FACTOR G':	\$ 1,586.93
TOTAL	\$ 11,001.07	TOTAL	\$ 36,425.04