



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

July 22, 2008

Mr. Darin J. Gordon
Director
Bureau of TennCare
Department of Finance and Administration
310 Great Circle Road
Nashville, TN 36243

Dear Mr. Gordon:

We are pleased to inform you that Amendment #6 to the Tennessee Medicaid section 1115 demonstration, TennCare II (11-W-00151/4), is approved. This amendment clarifies that the section 1115 demonstration benefits for home health benefits will be covered if they are determined to be medically necessary and in accordance with the definitions and limitations included in State rules (which model the Medicare benefit for these services). In addition, the private duty nursing benefit will be provided when necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both the equipment and patient are required.

The State may begin implementation of the revised TennCare Medicare and TennCare Standard Benefits for Home Health and Private Duty Nursing Services upon the date of this approval letter. This amendment is approved through June 30, 2010, upon which date, unless reauthorized, all waivers and authorities granted to operate this demonstration will expire. Approval of the project modifications is granted under the authority of section 1115(a) of the Social Security Act.

Enclosed please find revised Special Terms and Conditions governing the TennCare demonstration. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this list, shall continue to apply to the demonstration.

Should you have any further questions, please direct them to Ms. Kelly Heilman, the Project Officer for the Tennessee section 1115 Demonstration. She can be contacted at 410-786-1451 or at kelly.heilman@cms.hhs.gov. We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Kerry Weems
Acting Administrator

Enclosures

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cc: Jay Gavens, Acting ARA, Region IV

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)
AMENDED JULY 2008**

NUMBER: 11-W-00151/4 (Title XIX)

TITLE: TennCare II

AWARDEE: Tennessee Department of Finance and Administration

DEMONSTRATION EXTENSION PERIOD: October 5, 2007, through June 30, 2010*

Note: Temporary Extensions were granted under previous STCs from July 1, 2007, through October 4, 2007.

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 5, 2007, through June 30, 2010, as amended July 2008.

V. BENEFITS

- 27. TennCare Benefits.** TennCare covers physical and behavioral benefits provided through managed care delivery systems.
- All mandatory and optional Medicaid State plan eligible adults aged 21 or older and the Transition Group (see paragraph 23) enrolled in TennCare Medicaid receive all services covered under Tennessee’s State plan according to the limitations specified in the State plan, including the services identified in paragraph 29 as appropriate. Additional benefits are provided as specified in Table 2 and paragraph 28.
 - The other Demonstration-only eligible adults enrolled in TennCare Standard receive all State plan services, except as specified in Table 2 and paragraph 29. Additional benefits are provided as specified in Table 2 and paragraph 28.
 - All mandatory and optional Medicaid State plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all State plan and EPSDT covered services.
 - The Demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the State plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 29.
 - The Medicaid State plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women are covered for all TennCare Medicaid benefits, because the State considers that all of these services are pregnancy-related services.

The following table (Table 2) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those identified in the State plan. All benefits are limited by medical necessity as defined by the State.

Table 2—TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations

Service	TennCare Medicaid and TennCare Standard Coverage for Adults	State Plan Coverage for Adults
Diagnostic services	Covered as medically necessary.	Not covered.
Home health	Covered as medically necessary <u>and in accordance with the definitions and limitations included in Attachment B.</u>	Coverage limited to 60 visits per enrollee per State fiscal year.
Hospice care	Covered as medically necessary.	Coverage limited to 210 days per enrollee per State fiscal year.
Inpatient and outpatient substance abuse services	Covered as medically necessary, with a lifetime limitation of 10 detox days and \$30,000 in lifetime benefits.	Not covered.
Inpatient hospital services	Covered as medically necessary.	Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per State fiscal year.

Service	TennCare Medicaid and TennCare Standard Coverage for Adults	State Plan Coverage for Adults
Lab and X-ray services	Covered as medically necessary.	Coverage limited to 30 occasions per enrollee per State fiscal year.
Medicare premiums and cost-sharing	<ul style="list-style-type: none"> • Not covered for the Discontinued Demonstration Group. • Covered for State plan eligibles and SSD enrollees (who are also QMB or SLMB eligible) who are Medicare beneficiaries (to the same extent that Medicare premiums and cost-sharing are covered for the Medically Needy under the State plan). For State plan eligibles, Medicare premiums and cost-sharing are carved out of TennCare Medicaid and paid fee-for-service. For QMB/SLMB eligible SSD enrollees, the Medicare premiums are carved out of TennCare Standard and paid fee-for-service, but payments of Medicare cost-sharing are covered under TennCare Standard. 	Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their classification under the State plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.)
Mental health case management services	Covered as medically necessary.	Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill.
Occupational therapy	Covered as medically necessary.	Not covered.
Organ and tissue transplants	Covered as medically necessary, except that experimental or investigational transplants are not covered.	Coverage limited to renal, heart, liver, corneal, and bone marrow transplants.
Outpatient hospital services	Covered as medically necessary.	Coverage limited to 30 visits per enrollee per fiscal year.
Outpatient rehabilitation services	Covered as medically necessary.	Coverage limited to mental health services provided by Community Mental Health Agencies.

Service	TennCare Medicaid and TennCare Standard Coverage for Adults	State Plan Coverage for Adults
Pharmacy services	<ul style="list-style-type: none"> • Not covered for the Discontinued Demonstration Group. • Covered for State plan and Transition Group eligibles in accordance with the State plan. • Covered for SSD eligibles, with the co-payments specified in Table 5 of paragraph 33. 	Coverage as specified in State plan.
Physical therapy services	Covered as medically necessary.	Not covered.
Physicians' services (including medical and surgical services furnished by a dentist)	<p><u>Outpatient services:</u> Covered as medically necessary.</p> <p><u>Inpatient services:</u> Covered as medically necessary.</p>	<p><u>Outpatient services:</u> Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists.</p> <p><u>Inpatient services:</u> Coverage limited to 20 visits per enrollee per State fiscal year for services other than heart, liver, and bone marrow transplants, which are limited to 43, 67, and 40 days, respectively.</p>
Preventive services	Covered as medically necessary.	Not covered.
Private duty nursing services	Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. <u>Definitions and limitations applicable to this service are contained in Attachment C.</u>	Not covered.
Psychiatric residential treatment services (outside of an IMD)	Covered as medically necessary.	Not covered.
Screening services	Covered as medically necessary.	Not covered.

Service	TennCare Medicaid and TennCare Standard Coverage for Adults	State Plan Coverage for Adults
Speech, hearing, and language services	Covered as medically necessary.	Not covered.
Vision services	Covered for the first pair of cataract glasses following cataract surgery.	Not covered.

28. Cost-Effective Alternatives. TennCare MCOs and TennCare Select may provide services not listed in the Medicaid State plan or in paragraph 27 of these STCs as allowed under their contract with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound and comply with the Federal requirements specified in paragraph 17. TennCare Select must demonstrate to the State that a service not listed as covered in the Medicaid State plan or in paragraph 27 is a cost-effective alternative, in order for the State to reimburse TennCare Select for the service. The State must demonstrate to CMS annually as part of the annual report described in paragraph 45 that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care requirements specified in paragraph 17.

29. Medicaid Benefits Carved Out Of the TennCare II Demonstration.

- a. The **“Base” Medicaid State plan services** identified in the bullets below are carved out of TennCare II. These services are provided, in accordance with the provisions of the Medicaid State plan, only to the mandatory and optional State plan eligibles and Transition Group eligibles enrolled in TennCare Medicaid. The other TennCare II Demonstration-only populations, which are eligible through the Demonstration’s expenditure authorities and enrolled in TennCare Standard, are not covered for these services. Expenditures for these “Base” services are not Demonstration expenditures (see paragraph 50(a)), are not included in the Demonstration’s budget neutrality, and should, therefore, be reported on the “Base” reporting schedules of the Form CMS-64 reports.
- Nursing facility services
 - Services in an intermediate care facility for the mentally retarded (ICF/MR)
 - State plan targeted case management services
 - Program of All-Inclusive Care for the Elderly (PACE)
 - Services covered by a home and community-based services waiver under section 1915(c) of the Social Security Act
 - Services covered through the State’s agreement under Title V of the Social Security Act
- b. Medicare Parts A and B Buy-In Premiums: Medicare Buy-In premiums are covered for dually eligible Medicaid State plan eligibles and for Standard Spend Down enrollees who meet the Qualified Medicare Beneficiary (QMB) or Specified Low Income Medicare Beneficiary (SLMB) eligibility requirements. However, these

payments are excluded from TennCare II and are reported as “Base” Medicaid expenditures on the CMS-64 reports.

- c. Medicare Co-payments and Deductibles (i.e., Medicare crossover claims): Medicare crossover claims are covered for dually eligible Medicaid State plan eligibles and for QMB/SLMB eligible Standard Spend Down enrollees.

- (i) For TennCare Medicaid enrollees who are dually eligible for Medicare and the Medicaid State plan, these expenditures are not Demonstration expenditures and are not included in the budget neutrality calculations; therefore report these as “Base” Medicaid expenditures on the CMS-64 reports.

- (ii) For the QMB/SLMB eligible SSD enrollees, these expenditures are included as Demonstration expenditures that are subject to budget neutrality; therefore report these Demonstration expenditures as “EG6E Expan Adult” on the CMS-64 reports. The SSD population is the only Demonstration population which includes for whom the State pays Medicare cost-sharing would be covered as a benefit for the medically needy under the State Plan (see paragraph 27).

- d. By December 31, 2008, the State is required to submit an analysis of the number and percentage of the SSD population that is eligible for Medicare and, of them, the number and percentage that are eligible as QMBs or SLMBs. Such a report is also required to be included in the next request for the Demonstration’s extension.

30. Changes to TennCare II Benefits. Changes to TennCare II benefits described in the State plan shall be made by State plan amendment. Changes to TennCare II benefits not described in the State plan shall be made by amendment to the Demonstration, in accordance with paragraphs 7 and 8 of these STCs. Changes in benefits shall be implemented in accordance with the process set forth in Section XII of these STCs.

31. Institutions for Mental Diseases (IMDs). Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

Attachment B

Limitations on Home Health Services

Home health services are delivered in accordance with 42 CFR 440.70. Prior authorization may be required. Definitions and coverage limitations used by the State are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.
 - a. Part-time or intermittent nursing services.
 - (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.
 - (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on a prn (as needed) basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.
 - b. Home health aide services.
 - (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

- (2) The above limits may be exceeded when medically necessary for children under the age of 21.
 - c. Physical therapy, occupational therapy, or speech pathology and audiology services.
 - d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.
2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:
- a. The child is non-ambulatory; and
 - b. The child has no or extremely limited ability to interact with caregivers; and
 - c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and
 - d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

Attachment C

Limitations on Private Duty Nursing Services

Private duty nursing services are delivered in accordance with 42 CFR 440.80. Prior approval may be required. Definitions and coverage limitations used by the State are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home, that determines whether the nursing services are continuous or intermittent.
2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:
 - a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and
 - b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and
 - c. Are willing and available as needed to meet the recipient's non-nursing support needs.
3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:
 - a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

- b. Has a functioning tracheostomy
 - (1) Requiring suctioning, AND
 - (2) Oxygen supplementation, AND
 - (3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.
 - (4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:
 - (I) Medication
 - (a) Receiving medication via a gastrostomy tube (G-tube), OR
 - (b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND
 - (II) Nutrition
 - (a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR
 - (b) Receiving total parenteral nutrition.
- 4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.
- 5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of Subparagraph (a) may receive medically necessary nursing care as an intermittent service under home health.
- 6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services

are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

- a. The child is non-ambulatory; and
- b. The child has no or extremely limited ability to interact with caregivers; and
- c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and
- d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.