LONG TERM SERVICES & SUPPORTS

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Nursing Facility Level of Care (LOC) Guide

For TennCare CHOICES and PACE

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Introduction and Overview of TennCare NF LOC Changes

Nursing facility (NF) level of care (LOC) is one of two eligibility components (the other is financial eligibility) for Medicaid reimbursement of NF services, as well as home and community based services (HCBS) offered as an alternative to people who would otherwise qualify to receive NF care.

Each State sets its own NF LOC criteria. Approval by the Centers for Medicare and Medicaid Services (CMS) is not required.

Generally, LOC determinations include either an assessment of certain functional needs—the need for assistance with Activities of Daily Living (ADLs); an assessment of certain clinical needs; or both.

Activities of Daily Living (ADLs) consist of self-care tasks that enable a person to live independently in his own home such as:

- Personal hygiene and grooming;
- Dressing and undressing;
- Self feeding;
- Functional transfers (getting into and out of bed or wheelchair, getting onto or off toilet, etc.);
- Bowel and bladder management; and
- Ambulation (walking without use of an assistive device (walker, cane, or crutches) or using a wheelchair).

LOC determinations may also include consideration of other factors which, while not ADLs per se, nonetheless impact a person's ability to live safely and independently in the community, such as:

- Communication;
- Cognitive status;
- Behavior; or
- The ability to self-administer medications.

And finally, LOC determinations may take into consideration the applicant's medical or clinical needs such as:

- The need for skilled nursing or rehabilitative care.

The ADL and clinical needs assessed for NF LOC vary by state.

In Tennessee, the NF LOC process includes review of the applicant's:

1) Need for assistance with only the following ADLs:
    - Transfer;
    - Mobility;
    - Eating; and
    - Toileting;

2) Deficits in only the following ADL-related functions:
    - Communication (expressive and receptive);
    - Orientation (to person and place);
    - Dementia-related behaviors; and
    - Self-administration of medications; and

3) Certain skilled and/or rehabilitative needs (e.g., tube feeding, wound care, OT/PT, ventilator care).

Prior to July 1, 2012, ***only* one** significant deficit in any of these areas was sufficient to satisfy the "need for inpatient care" provision of NF LOC eligibility in Tennessee. This was a relatively minimal standard when compared to most other states.

As the population ages and the demand for long term services and supports (LTSS) increases, the State must raise the NF LOC standard to target more expensive institutional services to new applicants with higher acuity of need, while continuing to make HCBS more broadly available to applicants that do not meet the new higher NF standard but would be "at risk" of NF placement absent the provision of HCBS. This will help the State stretch limited dollars in order to serve more people, which is particularly important as the population ages and more and more people need LTSS.

These changes were contemplated when the CHOICES program was originally envisioned and included in the Long Term Care Community Choices Act of 2008, which authorized the program (see excerpt on page 3). The changes will apply to the CHOICES program, as well as the Program of All-inclusive Care for the Elderly (PACE).

TennCare has <u>not</u> simply raised the number of deficits required to meet NF LOC. Rather, we are using an approach that assesses the same ADLs, ADL-related and clinical criteria assessed prior to July 1, 2012, and weights each of those components on a scale of 0 up to a maximum of 5, depending on the amount of assistance that would be required for a person with that type and level of deficit.

Eligibility for NF services is based on each applicant's cumulative score, which reflects the acuity of that person's needs. In some instances, 3 ADL deficits will qualify a person for NF care (or comprehensive HCBS). In some instances only 2 ADL deficits and the need for a skilled service will qualify a person for NF care. And in some instances, it may require deficits in 4 or more ADLs, ADL-related or skilled or rehabilitative needs to qualify for NF LOC.

This is a more flexible approach which 1) recognizes that not all ADLs, ADL-related functions or clinical needs are alike; 2) takes into consideration those types of needs that may require more assistance; and 3) provides some consideration for lesser levels of need for assistance with a particular ADL or ADL-related function (not just if the applicant is "never" or "usually not" independent in performing the function as it was prior to July 1, 2012).

While each State's NF LOC criteria are different, these changes will help to bring Tennessee more in line with other States.

These changes do <u>not</u> affect anyone already enrolled in and receiving NF services or HCBS in CHOICES or in PACE as of June 30, 2012, unless there is a lapse in the member's TennCare or CHOICES eligibility or enrollment. CMS approved allowing the State to "grandfather" existing NF residents and those already receiving home-based care so long as they continue to meet the LOC criteria in place at the time of enrollment and remain continuously eligible and enrolled in the CHOICES Group or PACE, as applicable.

The new criteria will be applied *only* to new people seeking enrollment into: 1) CHOICES Group 1 for Medicaid-reimbursed NF services (including people enrolled in CHOICES Group 2 prior to July 1, 2012

that are seeking admission into a NF on or after July 1, 2012); 2) CHOICES Group 2 for a comprehensive package of HCBS offered as an alternative to NF care (except people enrolled in CHOICES Group 1 prior to July 1, 2012 that are transitioning to CHOICES Group 2); or 3) PACE; as well as 4) people enrolled in CHOICES prior to July 1, 2012, who subsequently have a gap in TennCare or CHOICES eligibility or enrollment.

Moreover, new applicants that do not meet the new higher NF LOC standard in effect as of July 1, 2012, but that would have qualified under the LOC criteria in place prior to July 1, 2012 (to be called the new "At Risk LOC"), will still be eligible to receive home-based care in a new CHOICES Group 3 for persons "at risk" of NF placement.

This new group will be eligible to receive HCBS, based on their needs, up to a total cost of $15,000 per year excluding the cost of minor home modifications. Community-based residential alternatives to institutional care (including Assisted Care Living Facility Services, Adult Care Homes and consumer directed Companion Care services) by definition, offer a cost-effective, community-based alternative to care in a NF, and are not covered for persons in Group 3 who do not meet NF LOC and would not qualify for TennCare-reimbursed care in a NF.

People with more extensive needs (that qualify to receive care in a NF based on the new criteria) will qualify to receive the more comprehensive package of HCBS and will not be subject to the $15,000 limit.

This is a critical next step in helping the State continue to expand access to home-based care, delay and/or prevent the need for NF placement, when appropriate, and rebalance the State's LTSS system for the elderly and adults with physical disabilities.

Public Chapter 1190: The Long-term Care Community Choices Act of 2008
(now codified at TCA 71-5-1407)

SECTION 8. (a) The commissioner shall develop level of care criteria for new nursing facility admissions which ensure that the most intensive level of long-term care services is provided to persons with the highest level of need…

(b) Nursing facility residents who meet continued stay criteria and who remain financially eligible for Medicaid shall continue to be eligible to receive nursing facility services or cost-effective home and community based waiver services, and shall not be required to meet new nursing facility level-of-care criteria.

(c) Current enrollees in the statewide home and community-based services waiver program for persons who are elderly and/or adults with physical disabilities who meet continued stay criteria and remain financially eligible for Medicaid shall continue to be eligible to receive cost-effective home and community-based waiver services and shall not be required to meet new nursing facility level-of-care criteria except for admission to a nursing facility.

(d) The commissioner shall develop and seek approval of a waiver application or amendment thereto which allows persons who meet a lesser level of care, i.e., who do not meet new nursing facility level-of-care criteria, but are "at risk" of institutional care, to qualify for a more moderate package of Medicaid-reimbursed home and community-based waiver services up to a specified enrollment cap.

TennCare Level of Care Eligibility

There are two components of level of care (LOC) eligibility (see current TennCare Rule 1200-13-01-.10):

- Medical necessity of care; and
- Need for inpatient care.

Both components are applicable to Nursing Facility (NF) LOC as well as the At-Risk LOC that will be implemented on July 1, 2012.

1. **Medical Necessity of Care**

For persons requesting care in a Nursing Facility:

Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent deterioration in health status, or to delay progression of a disease or disability, **and** such care must be ordered and supervised by a physician on an ongoing basis.

For persons requesting HCBS in CHOICES or PACE:

Care is not provided *in a Nursing Facility*, but instead in the home or community setting. Rather than being *expected to improve or ameliorate the individual's physical or mental condition, to prevent deterioration in health status, or to delay progression of a disease or disability*, the purpose of HCBS is primarily to allow the person to continue living safely in the community and to delay or prevent placement in a NF. And, while HCBS do not require a Physician's Order, such services must be specified in an approved plan of care, and like NF services, must be needed by the individual *on an ongoing basis*.

Thus, medical necessity of care as it relates to HCBS is as follows:

HCBS must be required in order to allow the person to continue living safely in the home or community-based setting and to prevent or delay placement in a nursing facility, and such HCBS must be specified in an approved plan of care and needed *on an ongoing basis*.

- The need for *one-time* HCBS is not sufficient to meet medical necessity of care for HCBS.
- If a person's ongoing need for assistance with activities of daily living and/or instrumental activities of daily living can be met through the provision of assistance by family members and/or other caregivers, or through the receipt of services available to the member through community resources (e.g., Meals on Wheels) or other payer sources (e.g., Medicare), he does not require HCBS in order to continue living safely in the home and community-based setting and to prevent or delay placement in a nursing facility.

2. **Need for Inpatient Care Effective July 1, 2012**

For persons requesting care in a Nursing Facility:

The individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must:

- Have a total acuity score of at least 9 on the TennCare NF LOC Acuity Scale; or
- Meet or equal one or more of the criteria listed on page 6 on an ongoing basis **and** be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (persons "at risk" of NF placement).

For persons eligible to receive care in a NF, but requesting HCBS in CHOICES or PACE:

While persons receiving HCBS must have a physical or mental condition, disability or impairment (as determined by the functional criteria listed on page 6), such impairment does not necessarily have to require daily *inpatient nursing care*, but instead, must require ongoing supervision and assistance with activities of daily living in the home or community setting. While services do not have to be required on a *daily* basis, the need for assistance must be ongoing such that the person would otherwise require placement in a NF in order to be eligible to receive HCBS.

Thus, the need for inpatient care as it relates to persons eligible to receive care in a NF, but requesting HCBS is as follows:

The member has a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of such HCBS, the person would require and must qualify to receive NF services in order to remain eligible for HCBS. The individual must be unable to self-perform needed assistance and must:

- Have a total acuity score of at least 9 on the TennCare NF LOC Acuity Scale; or
- Meet or equal one or more of the criteria listed on page 6 on an ongoing basis **and** be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (persons "at risk" of NF placement).

For persons not eligible to receive care in a NF, but "at risk" of NF placement and requesting HCBS in CHOICES:

Like persons requesting HCBS who meet NF LOC, persons requesting HCBS who are "at risk" of NF placement must have a physical or mental condition, disability or impairment (as determined by the functional criteria listed on page 6). Similarly, the person does not necessarily have to require daily *inpatient nursing care*, but instead, must require ongoing supervision and/or assistance with activities of daily living in the home or community setting. While services do not have to be required on a *daily* basis, the need for assistance must be ongoing such that the person would otherwise not be able to safely live in the community and would be at risk of placement in a NF in order to be eligible to receive HCBS.

Thus, the need for inpatient care as it relates to persons not eligible to receive care in a NF, but requesting HCBS is as follows:

The member has a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of such HCBS, the person would not be able to live safely in the community and would be at risk of NF placement. The individual must be unable to self-perform needed assistance and must meet or equal one or more of the criteria below on an ongoing basis.

The member must remain unable to self-perform nursing care (for NF services) or require supervision and/or assistance with activities of daily living (for HCBS), and must meet or equal one or more of the following criteria on an ongoing basis:

a. Transfer - Member is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (4 or more days per week).

b. Mobility - Member requires physical assistance from another person for mobility on an ongoing basis (4 or more days per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid does not by itself satisfy this requirement.

c. Eating - Member requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and/or assistance in cutting up foods do not satisfy this requirement.

d. Toileting - Member requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (4 or more days per week).

e. Expressive and Receptive Communication - Member is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

f. Orientation - Member is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

g. Medication Administration - Member is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

h. Behavior - Member requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).

i. Skilled Nursing or Rehabilitative Services - Member requires certain daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The above criteria should reflect the member's capabilities *on an ongoing basis* and not isolated, exceptional, or infrequent limitations of function in a generally independent person who is able to function with minimal supervision or assistance.

Additional Eligibility Criteria for Higher Levels of NF Reimbursement

For persons who meet NF LOC, eligibility for higher levels of NF reimbursement shall include the following:

Level 2 NF Reimbursement

The member must have a physical or mental condition, disability, or impairment that requires one or more of the skilled nursing or rehabilitative services for which Level 2 NF reimbursement may be authorized by TennCare. The need for such service must be supported by the medical evidence submitted with the PAE.

The individual must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. The applicant must require the skilled service on a daily basis and/or the rehabilitative service at least five (5) days per week, pursuant to a physician's order.

In addition, the individual must be mentally or physically unable to perform the needed skilled services or the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed.

a. Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, does not satisfy this requirement.

b. Nursing observation and assessment do not satisfy this requirement.

A skilled rehabilitative service must be expected to improve the individual's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurse aides) do not satisfy this requirement.

Level 2 NF Care at the Chronic Ventilator Rate of Reimbursement

The member is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula), and must require ventilator services by an appropriately licensed professional pursuant to a physician's order.

Level 2NF Care at the Tracheal Suctioning Rate of Reimbursement

The member has a functioning tracheostomy and requires suctioning through the tracheostomy by an appropriately licensed professional at a minimum, multiple times per eight (8) hour shift, pursuant to a physician's order. The suctioning must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by the patient's spontaneous effort. Suctioning of the nasal or oral cavity does not qualify for this higher level of reimbursement.

The TennCare Nursing Facility Level of Care Acuity Scale

Effective July 1, 2012, for all new applicants, level of care (LOC) eligibility for TennCare-reimbursement of NF services shall be based on an assessment of the following measures:

1) The applicant's need for assistance with the following Activities of Daily Living (ADLs):
   - Transfer;
   - Mobility;
   - Eating; and
   - Toileting;

2) The applicant's level of independence (or deficit) in the following ADL-related functions:
   - Communication (expressive and receptive);
   - Orientation (to person and place);
   - Dementia-related behaviors; and
   - Self-administration of medications; and

3) The applicant's need for certain skilled and/or rehabilitative services.

One or more questions on the CHOICES Pre Admission Evaluation (PAE) shall be used to assess each of the ADL or related measures specified above.

These are the *same* ADL or related measures assessed for NF LOC prior to July 1, 2012, including the same questions and possible responses.

However, because only one significant ADL or related deficiency is no longer sufficient to meet NF LOC, it is critical that qualified persons submitting a PAE complete the PAE in its entirety, being careful to accurately assess each functional area and to submit sufficient medical evidence to support the assessed level of function, and that Qualified Assessors are thorough in their review of the assessment and supporting documentation prior to certifying its accuracy.

While a PAE for which NF LOC has been denied can always be resubmitted, it is important to note that, pursuant to TennCare Rule 1200-13-01-.10(3)(b), " Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier than the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application." The effective date will be changed to "no more than ten (10) days prior to the date of receipt of the information which cured the original deficiencies in the denied PAE" in the Permanent Rule to become effective in late December 2012, but will in most cases not cover back to the date requested in the deficient application.

Weighted Values

On the PAE for NF LOC, there are currently 4 possible responses to each question. *Except* for behavior, **"Always"** means that the applicant is **always independent** with that ADL or related activity. **"Usually"**

means that the person is **usually independent** (requiring assistance fewer than 4 days per week). **"Usually not"** means that the applicant is usually not independent (requiring assistance 4 or more days per week). **"Never"** means that the applicant is **never independent** with that ADL or related activity.

With respect to behavior, the responses are reversed. **"Always"** means that the applicant always requires intervention for dementia-related behaviors. **"Usually"** means that the applicant requires intervention for dementia-related behaviors 4 or more days per week. **"Usually not"** means that the applicant requires intervention for dementia-related behaviors, but fewer than 4 days per week. **"Never"** means that the applicant does not have dementia-related behaviors that require intervention.

TennCare has assigned a weighted value to each of the possible responses to each question on the CHOICES PAE, based on the amount of assistance that would be required for a person with that type and level of ADL or related deficit. **The response must be supported by the medical evidence submitted with the PAE.**

The **weighted value** of each of the potential responses to a question regarding the ADL or related functions specified above shall be as follows:

ADL (or related) question	Condition	Always	Usually	Usually not	Never	Maximum Individual Acuity Score	Maximum Acuity Score for the Measure(s)
Transfer	Highest value of two measures	0	1	3	4	4	4
Mobility		0	1	2	3	3	
Eating		0	1	3	4	4	4
Toileting	Highest value of three questions for the toileting measure	0	0	1	2	2	3
Incontinence care		0	1	2	3	3	
Catheter/ ostomy care		0	1	2	3	3	
Orientation		0	1	3	4	4	4
Expressive communication	Highest value of two questions for the communication measure	0	0	0	1	1	1
Receptive communication		0	0	0	1	1	
Self-administration of medication	First question only; excludes SS insulin	0	0	1	2	2	2
Behavior		3	2	1	0	3	3
Maximum possible ADL (or related) Acuity Score							**21**

TennCare has also assigned a weighted value to each of the skilled and/or rehabilitative services for which level 2 or enhanced respiratory care NF reimbursement could be authorized, when determined by TennCare to be needed by the applicant on a daily basis or at least five days per week for rehabilitative services, based on the medical evidence submitted with the PAE.

For any applicant who requires one or more of the specified skilled nursing or rehabilitative services and at a frequency (daily for each of the specified skilled services and at least five (5) days per week for each

of the specified rehabilitative services) for which level 2 NF reimbursement may be approved by TennCare, the submitter should complete the applicable portions of the PAE and include documentation would be required for determination of eligibility for level 2 or enhanced respiratory care NF reimbursement (as applicable), regardless of whether the applicant's care will be provided in a NF or in the community.

A Physician's Order will not be required if the skilled or rehabilitative services are being performed by a family member under a specified exemption to the Nurse Practice Act. However, the request must include medical records sufficient to document the need for each skilled or rehabilitative service(s), including the frequency of each service, as would be required for determination of eligibility of a higher level of NF reimbursement. This information will be used for purposes of determining the applicant's total acuity score (regardless of setting), as well as the applicant's cost neutrality cap if enrolled in CHOICES Group 2.

The weighted value for each of the skilled and/or rehabilitative services for which level 2 NF reimbursement could be authorized shall be as follows:

Skilled or rehabilitative service	Maximum Individual Acuity Score
Ventilator	5
Frequent tracheal suctioning	4
New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours	3
Total Parenteral Nutrition (TPN)	3
Complex wound care (i.e., infected or dehisced wounds)	3
Wound care for stage 3 or 4 decubitus	2
Peritoneal dialysis	2
Tube feeding, enteral	2
Intravenous fluid administration	1
Injections, sliding scale insulin	1
Injections, other IV, IM	1
Isolation precautions	1
PCA pump	1
Occupational Therapy by OT or OT assistant	1
Physical Therapy by PT or PT assistant	1
Teaching catheter/ostomy care	0
Teaching self-injection	0
Other	0
Maximum Possible Skilled Services Acuity Score	**5**

An **individual acuity score** is the weighted value assigned to:

1) The response to a specific ADL or related question in the TennCare CHOICES PAE that is supported by the medical evidence submitted with the PAE; or

2) A specific skilled or rehabilitative service determined by TennCare to be needed by the applicant based on the medical evidence submitted with the PAE.

Conditions:

1. **Maximum Acuity Score for Transfer and Mobility**

Assessment of the need for assistance with transfer and the need for assistance with mobility are separate but overlapping measures of an applicant's physical independence (or dependence) with movement.

The maximum individual acuity score for transfer shall be 4.

The maximum individual acuity score for mobility shall be 3.

The highest individual acuity score among the transfer and mobility measures shall be the applicant's total acuity score across both measures.

The maximum acuity score across both the transfer and mobility measures shall be 4.

2. **Maximum Acuity Score for Toileting**

Assessment of the need for assistance with toileting shall include the following:

1) An assessment of the applicant's need for assistance with toileting;
2) Whether the applicant is incontinent, and if so, the degree to which the applicant is independent in incontinence care; and
3) Whether the applicant requires a catheter and/or ostomy and if so, the degree to which the applicant is independent with catheter and/or ostomy care.

The highest individual acuity score among each of the 3 toileting questions shall be the applicant's total acuity score for the toileting measure.

The maximum acuity score for toileting shall be 2.

3. **Maximum Acuity Score for Communication**

Assessment of the applicant's level of independence (or deficit) with communication shall include an assessment of expressive as well as receptive communication.

The highest individual acuity score across each of the 2 communication questions shall be the applicant's total score for the communication measure.

The maximum possible acuity score for communication shall be 1.

4. **Maximum Acuity Score for Self-Administration of Medication**

Assessment of the applicant's level of independence (or deficit) with self-administration of medications as an ADL-related function shall not take into consideration whether the applicant requires sliding scale insulin and the applicant's level of independence in self-administering sliding scale insulin.

Sliding scale insulin shall be considered along with other skilled and/or rehabilitative services for which TennCare could authorize level 2 NF reimbursement .

The maximum individual acuity score for self-administration of medication shall be 2.

The maximum individual acuity score for sliding scale insulin shall be 1.

5. Maximum Skilled Services Acuity Score

The highest individual acuity score across all of the skilled and/or rehabilitative services shall be the applicant's total acuity score for skilled and/or rehabilitative services.

The maximum possible acuity score for skilled and/or rehabilitative services shall be 5.

Maximum Acuity Score

The maximum possible acuity score for Activities of Daily Living (ADL) or related deficits shall be 21.

The maximum possible acuity score for skilled and/or rehabilitative services shall be 5.

The maximum possible total NF LOC acuity score shall be 26.

Determining the Applicant's Acuity Score

The applicant's acuity score for each functional measure (or in the case of transfer and mobility, across both measures) will be added in order to determine the applicant's total ADL or related acuity score (up to a maximum of 21). The applicant's total ADL or related acuity score will then be added to the applicant's skilled services acuity score (up to a maximum of 5) in order to determine the applicant's total acuity score (up to a maximum of 26).

Example A

Based on responses to questions in the PAE and supported by medical evidence submitted with the PAE, Applicant A is "Never" independent with transfer, mobility, eating or toileting, but is continent and does not have a catheter or ostomy. In addition, Applicant A is "Never" independent in administration of medication, despite the provision of assistance as specified in the PAE. Applicant A is "Always" oriented to person and place and "Always" independent in expressive and receptive communication. Applicant A "Never" requires intervention for dementia-related behaviors. Applicant A does not require any of the specified skilled or rehabilitative services for which Level 2 NF reimbursement would be authorized.

- The acuity score for the transfer measure is 4.
- The acuity score for the mobility measure is 3.
- The combined acuity score across the transfer and mobility measures is 4 (the highest value across the two measures).
- The acuity score for the eating measure is 4.

- The acuity score for the first toileting question is 2.
- The acuity scores for the incontinence and catheter/ostomy care questions are each 0.
- The acuity score for the toileting measure is 2 (the highest value of three possible questions for the toileting measure).
- The acuity score for the orientation measure is 0.
- The acuity score for expressive communication is 0.
- The acuity score for receptive communication is 0.
- The acuity score for the communication measure is 0 (the highest value of two possible questions for the communication measure).
- The acuity score for the self-administration of medication measure is 2.
- The acuity score for the behavior measure is 0.
- The total ADL or related acuity score is 12.
- The skilled services acuity score is 0.
- The applicant's total acuity score is 12.

Example B

Based on responses to questions in the PAE and supported by medical evidence submitted with the PAE, Applicant B (who has dementia) is "Always" independent with transfer, mobility, eating and all aspects of toileting; "Never" oriented to person and place; "Always" independent with expressive communication and "Usually" independent with receptive communication; "Never" independent with self-administration of medication, despite the provision of assistance as specified in the PAE (due to cognitive impairments); and "Always" requires intervention for persistent dementia-related behaviors. Applicant B does not require any of the specified skilled or rehabilitative services for which Level 2 NF reimbursement would be authorized.

- The acuity score for the transfer measure is 0.
- The acuity score for the mobility measure is 0.
- The combined acuity score across the transfer and mobility measures is 0 (the highest value across the two measures).
- The acuity score for the eating measure is 0.
- The acuity score for each of the toileting questions is 0.
- The acuity score for the toileting measure is 0 (the highest value of three possible questions for the toileting measure).
- The acuity score for the orientation measure is 4.
- The acuity score for expressive communication is 0.
- The acuity score for receptive communication is 0.
- The acuity score for the communication measure is 0 (the highest value of two possible questions for the communication measure).
- The acuity score for the self-administration of medication measure is 2.
- The acuity score for the behavior measure is 3.
- The total ADL or related acuity score is 9.
- The skilled services acuity score is 0.
- The applicant's total acuity score is 9.

Qualifying for NF LOC

To satisfy "the need for inpatient care" provision of NF LOC, applicants requesting to receive care in a NF, as well as applicants eligible to receive care in a NF, but requesting HCBS (in CHOICES Group 2 or PACE) must:

1) Have a total acuity score of at least 9; or
2) Meet At-Risk LOC **and** be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (persons "at risk" of NF placement).

For purposes of the need for inpatient care provision of NF LOC (for persons requesting care in a NF and for persons eligible to receive care in a NF, but requesting HCBS in CHOICES Group 2 or PACE), a determination by TennCare that the person does not qualify to enroll in CHOICES Group 3 shall be based only upon one (1) of the following*:

1) Denial of enrollment into CHOICES Group 3 by TennCare because:

   a) The applicant is not in the defined target population (age 65 or older or age 21 or older with physical disabilities); or

   b) TennCare has determined that the applicant's needs cannot be safely and appropriately met in the community with the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers.

*NOTE: There are additional reasons for which a person may not qualify to enroll in CHOICES Group 3. For example, a person may be denied enrollment into CHOICES Group 3 because he is not currently an SSI recipient and does not qualify in the new demonstration eligibility category established for CHOICES Group 3 applicants based on NF financial eligibility criteria, or the applicant is in an asset transfer penalty period for giving away or selling assets at less than their fair market value within 60 months prior to applying for Medicaid reimbursement of LTSS. In this case, the applicant would not qualify to enroll in *any* CHOICES Group.

2) Termination of enrollment from CHOICES Group 3 by TennCare because TennCare has determined that the applicant's needs cannot be safely and appropriately met in the community with the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers.

3) Advance determination by TennCare that the applicant would not qualify for enrollment into CHOICES Group 3 only if ***all*** of the following criteria are met:

   a) The applicant has a total acuity score of at least six (6) but no more than eight (8);
   b) The applicant has an individual acuity score of at least three (3) for the Orientation measure (i.e., "Never" or "Usually not" oriented to person and place);
   c) The applicant has an individual acuity score of at least two (2) for the Behavior measure (i.e., "Always" or "Usually" requires intervention for dementia-related behaviors);

d) The absence of intervention and supervision at the frequency specified in the PAE would result in imminent and serious risk of harm to the applicant and/or others (documentation of the specific behaviors, the frequency of such behaviors, and the imminence and seriousness of risk shall be required);
e) Sufficient evidence, as required and determined by TennCare, to demonstrate that the necessary intervention and supervision needed by the person cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers.

A. Documentation required to support an advance determination shall include ***all*** of the following:

1) A comprehensive needs assessment performed by an MCO Care Coordinator pursuant to requirements set forth in the MCO's Contractor Risk Agreement, including:

(a) As assessment of the member's physical, behavioral, functional, and psychosocial needs;
(b) An assessment of the member's home environment in order to identify any modifications that may be needed and to identify and address any issues that may affect the member's ability to be safely served in the community;
(a) An assessment of the member's natural supports, including care being provided by family members and/or other caregivers, and long-term care services the member is currently receiving (regardless of payer), and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver or payer; and
(b) An assessment of the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health, safety and welfare in the community and to prevent the need for institutional placement. Such assessment shall specify the specific tasks and functions for which assistance is needed by the member, the frequency with which such tasks must be performed, and the amount of paid assistance necessary to perform these tasks;

2) A person-centered plan of care developed by the MCO Care Coordinator which specifies the CHOICES HCBS that would be necessary and that would be approved by the MCO to safely support the person in the community, including non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers (or attestation that the person could not be safely supported in the community with *any* combination of services and supports, as applicable);

3) Explanation regarding why an array of covered services and supports, including CHOICES HCBS within the $15,000 expenditure cap for CHOICES 3 and non-CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the person's needs in the community.

4) Detailed explanation of: a) the member's living arrangements and the services and supports the member has received for the six (6) months prior to application for CHOICES, including non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers; and b) any recent significant event(s) or circumstances that have impacted the applicant's need for services and supports, including how such event(s) or circumstances would impact the person's ability to be safely supported within the array of covered services and supports that would be available if the person were enrolled in CHOICES Group 3.

B. For persons not enrolled in TennCare at the time the PAE is submitted:

1) A comprehensive assessment, including an assessment of the applicant's home environment, performed by the AAAD, or the most recent MDS assessment performed by a Nursing Facility contracted with one or more TennCare MCOs may be submitted in lieu of the MCO assessment specified in item (1) above.

2) The person-centered plan of care as described in item (2) above shall not be required.

PAE Effective Dates Pertaining to Advance Determinations for Persons Not Enrolled in TennCare when the PAE is Submitted

<u>When an Advance Determination is Approved</u>

Advance determination by TennCare that a person not enrolled in TennCare at the time the PAE is submitted cannot be safely supported within the array of services and supports that would be available if the person were enrolled in CHOICES 3 and approval of NF LOC shall be effective for no more than thirty (30) days, pending a comprehensive assessment and plan of care developed by the MCO Care Coordinator once the person is eligible for TennCare and enrolled in CHOICES Group 1 or 2.

Comprehensive documentation as detailed in items A(1) through A(4) above shall be submitted by the MCO and reviewed by TennCare in order to determine the applicant's level of care eligibility going forward.

<u>When an Advance Determination is Not Approved</u>

If TennCare determines that an advance determination cannot be approved for an applicant already admitted to a NF who is not enrolled in TennCare at the time the PAE is submitted, but subsequently upon enrollment into CHOICES Group 3 and receipt of comprehensive documentation submitted by the MCO, determines that the applicant's needs cannot be safely and appropriately met in the community with the array of services and supports available in CHOICES Group 3, enrollment in CHOICES Group 3 will be terminated and NF LOC will be approved. In such case, the effective date of 1) NF LOC; and 2) enrollment into CHOICES Group 1 (subject to all applicable enrollment requirements for CHOICES Group 1) will be the date that NF LOC would have been effective had an advance determination been approved.

ATTACHMENT A

TennCare
Nursing Facility
Level of Care
Acuity Scale

TennCare Nursing Facility Level of Care Acuity Scale

ADL (or related) Deficiencies

		Weights					
Functional Measure	**Condition**	**Always**	**Usually**	**Usually Not**	**Never**	**Max Individual Score**	**Max Acuity Score**
Transfer	Highest value of two measures	0	1	3	4	4	4
Mobility		0	1	2	3	3	
Eating		0	1	3	4	4	4
Toileting	Highest value of three possible questions for the toileting measure	0	0	1	2	2	3
Incontinence care		0	1	2	3	3	
Catheter/ostomy care		0	1	2	3	3	
Orientation		0	1	3	4	4	4
Expressive communication	Highest value of two possible questions for the communication measure	0	0	0	1	1	1
Receptive communication		0	0	0	1	1	
Self-administration of medication	First question only (excludes SS Insulin)	0	0	1	2	2	2
Behavior		3	2	1	0	3	3
Maximum Possible ADL (or related) Acuity Score							21

Skilled Services	
Ventilator	5
Frequent tracheal suctioning	4
New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours	3
Total Parenteral Nutrition (TPN)	3
Complex wound care (i.e., infected or dehisced wounds)	3
Wound care for stage 3 or 4 decubitus	2
Peritoneal dialysis	2
Tube feeding, enteral	2
Intravenous fluid administration	1
Injections, sliding scale insulin	1
Injections, other IV, IM	1
Isolation precautions	1
PCA pump	1
Occupational Therapy by OT or OT assistant	1
Physical Therapy by PT or PT assistant	1
Teaching catheter/ostomy care	0
Teaching self-injection	0
Other	0
Maximum Possible Skilled Services Acuity Score	**5**