GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Tennessee, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2024

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Tennessee, USA

In-Kind Benefits

Plan details 1992-2024 * †

Public long-term care (LTC) benefits in Tennessee are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Tennessee, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, Tennessee's Medicaid LTC system has been subject to two major policy reforms: the implementation of a new home and community-based services program for older adults in 2002, and the implementation of TennCare CHOICES in 2010 that reorganized LTC benefits for older adults under the state managed care system.

Key Dates

First law: 1965

Major changes since 1992: 2002, 2010

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2001

Overview

Long-term care (LTC) benefits in Tennessee are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Tennessee is administered at the state level by the Department of Finance and Administration, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that have different requirements, such as income and asset limits. LTC benefits in Tennessee are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care.

Benefit programs vary in dependence requirements. Home Health Services require the individual to have a medical necessity for services, while Nursing Facility beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

A number of minor LTC policy reforms occurred during this policy period. Effective January 1, 1994, Tennessee replaced its state Medicaid program with a managed care demonstration program called TennCare. It covered Medicaid eligibles, individuals who lacked access to health insurance as of March 1, 1993, and those who were considered "uninsurable" by having been turned down for health insurance due to a health condition. While Home Health Services were transitioned to TennCare, Nursing Facility Care was carved out and remained administered by the state under the fee-for-service system. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration. In 1999 the medically needy spend-down limit for one person increased from $175 to $241 per month.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023b)

Tennessee Law for Medicaid

- Tennessee Code Annotated Section 71-2-3: Medical Care for the Aged
- Tennessee Code Annotated Section 71-5-1: Medical Assistance Act
- Tennessee Code Annotated Section 71-5-14: Long-Term Care Community Choices Act of 2008
- Tennessee Comprehensive Rules & Regulations:
  - 1200-13-01: Tennessee Department of Finance and Administration, Bureau of Tenncare, General Rules (TDFA, 2003)
  - 1200-13-12: Tennessee Department of Finance and Administration, Bureau of Tenncare (TDFA, 2002)
  - 1200-13-16: Tennessee Department of Finance and Administration, Bureau of Tenncare, Medical Necessity (TDFA, 2006)
  - 1240-03-02: Tennessee Department of Human Services, Division of Medical Services, Coverage Groups Under Medicaid (TDHS, 1997)
  - 1240-03-03: Tennessee Department of Human Services, Division of Medical Services, Technical and Financial Eligibilty Requirements for Medicaid (TDHS, 1997)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Tennessee Medicaid spending on beneficiaries in fiscal year 1992 was 68.41%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (68.41% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Tennessee Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Tennessee.

Eligibility for Medicaid in Tennessee for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount. In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[1]
  - Citizenship/immigration requirements: The applicant must be a Tennessee resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[2] From 1997, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted uner Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023a) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[3]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI benefit amount. In 1992 this was $1,266 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $1,899 in income, but this only applies in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[4]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
    - Asset transfer: Same as eligibility track 1a.

  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be receiving Medicaid Nursing Facility Care.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled:
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is calculated on a monthly basis and is determined by subtracting the Medicaid Protected Income Level (PIL) from net countable income over a four month period. The resulting amount must be spent on qualifying medical bills and services in order to receive Medicaid coverage for the remainder of the month. PILs vary by family size. In 1992, the PIL was $175 for an individual and $258 for a couple or household of two. Effective July 1, 1999, the PIL for an individual was increased to $241 (Tennessee Department of Human Servicecs [TDHS], 1997; TDHS, 2003).
  - Asset requirements: Same asset requirements as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled.[3]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include (TDHS, 1997):

- Uninsurable: TennCare provides Medicaid coverage for individuals who are "uninsurable" (i.e., have been turned down for health insurance due to a medical condition) with incomes up to 100% of the federal poverty level (FPL). Premiums and copayments apply if income is above the FPL.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Program of All-Inclusive Care for the Elderly (PACE): The PACE program provides comprehensive medical and social services to some older adults still living in the community. In Tennessee, PACE was first implemented in 1999 and is only available to residents of Hamilton county.
- OPTIONS for Community Living: OPTIONS is a state-funded program providing HCBS including homemaker services, personal care, and home-delivered meals to individuals age 60 or older as well as adults age 18 or older living with disabilities.

Benefit

Home care benefit

Home Health Services

Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health visits are capped at 60 visits per year (Tennessee Department of Finance and Administration [TDFA], 2003).

Nursing Facility Care

Nursing Facility Care does not provide home care.

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care.

Residential care

Home Health Services

This program does not provide residential care.

Nursing Facility Care

Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment.

Other benefits

Tennessee Medicaid provides additional state plan benefits related to LTC (TDFA, 1990; TDFA, 2003):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed by the Tennessee Department of Human Services and overseen by the Tennessee Department of Finance and Administration. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services must be provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provide services through state-certified home health agencies (42 CFR 484.30-36; TDFA, 2002).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (42 CFR 483.30; TDFA, 2003).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the two largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. The physician must also certify that the individual is homebound, and prior authorization is required before a beneficiary can begin receiving home health services (TDFA, 1990; TDFA, 2003).

Nursing Facility Care

The beneficiary must have been a resident at a state-certified nursing facility for at least 30 days, and must meet an NFLOC by having a physician certify continuous need for nursing facility care (TDHS, 1992; TDHS, 2008b). The individual's Pre-Admission Evaluation (PAE) must demonstrate medical necessity of care, as well as the need for inpatient skilled nursing services on a daily basis. Retroactive eligibility can be approved for up to three months preceding the month of application, as long as the individual meets eligibility requirements at any time during the month (TDHS, 2003; TDFA, 2003).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the two largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 62 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (TDFA, 2003; 42 CFR 484.55).

Nursing Facility Care

NFLOC must be recertified according to the following schedule after initial certification of the beneficiary's Pre-Admission Evaluation (TDFA, 2003):

1. 60 days after the date of initial certification
2. 180 days after the date of the initial certification
3. 12 months after the date of the initial certification
4. 18 months after the date of the initial certification
5. 24 months after the date of the initial certification
6. every 12 months thereafter

After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly & annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.128, 42 CFR 483.20).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements may vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by the two largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the two largest programs are summarized below.

Home Health Services

Home health services must be medically necessary and ordered by a physician prior to receipt of services. The physician must also certify that the applicant is homebound, and that they require skilled nursing care or the services of a home health aide on an intermittent basis. To be certified as homebound the applicant must be confined to their home due to a medical condition, and only able to leave the home on brief and infrequent occasions primarily for the purposes of receiving medical care. Medical necessity of services are documented in the applicant's plan of care as well as in supporting diagnoses of medical care needs and the physical condition of the patient (TDFA, 1990; TDFA, 2003).

Nursing Facility Care

In order to qualify for nursing facility care, the care must be certified as medically necessary to improve or ameliorate the applicant's physical or mental condition, or to prevent a deterioration in health status. The applicant must demonstrate a need for skilled nursing facility level of care by requiring skilled nursing or rehabilitative services on a daily basis; by requiring services at greater frequency, duration, or intensity than would be provided through daily home health visits; and by being physically or mentally unable to self-administer the needed skilled services (Tennessee Comptroller of the Treasury [TCT], 2001).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the two largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a plan of care that establishes medical need for the ordered services as well as that the individual is homebound. A home health agency may also establish a written plan of care based on verbal orders by the individual's attending physician. A registered nurse or therapist must prepare the plan of care, and submit to the physician for their signature before provision of care can begin (TDFA, 1990; TDFA, 2003).

Nursing Facility Care

A Pre Admission Evaluation (PAE) that has been approved by the Bureau of TennCare is used to certify that the individual meets a nursing facility level of care (NFLOC) by documenting medical need for skilled nursing services. The PAE must be certified by a physician, and must include a recent history and physical that support the applicant's skilled nursing needs. The nursing facility assists the individual in applying for Medicaid and qualifying for nursing facility care by coordinating the PAE with their physician, helping to complete the necessary paperwork and relevant nursing facility documentation in support of the PAE, and obtaining PAE approval through the Bureau of TennCare (TDFA, 2003).

In addition to annual PAE recertifications, nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

Evaluators

Evaluators vary by LTC health benefit program. The details of the two largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (TDFA, 1990; TDFA, 2003).

Nursing Facility Care

A licensed physician must certify NFLOC and need for skilled nursing care, while the nursing facility is responsible for completing the Pre-Admission Evaluation (PAE) assessment, including coordinating with the beneficiary's physician for certification as well as submitting the PAE to the Bureau of TennCare for approval (TDFA, 2003).

Benefit limitations

Can you mix LTC benefits?

All Tennessee Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Tennessee implemented a Medicaid Estate Recovery program in 1994. The acceptance of Medicaid in Tennessee creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility services after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

Available Tennessee state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 1992, the PNA was $30 per month.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2002-2009

Policy change in 2002
In May 2002 the Centers for Medicare and Medicaid Services (CMS) approved a new program providing Home and Community-Based Services (HCBS) for the Elderly & Disabled. Services include case management, homemaker services, personal care services, home modifications, personal emergency response systems (PERS), home delivered meals, and respite care (TCT, 2003).

Other policy changes during this period:

- (2005) Effective January 1, the personal needs allowance (PNA) for nursing facility residents was increased from $30 to $40 per month (TDHS, 2008b).
- (2005) On April 19 the State closed eligibility track 3a (medically needy) to all new Medicaid enrollees except pregnant women and children. Beginning on May 21, 2006 a Standard Spend Down demonstration was implemented, extending the same medically needy spend-down requirements to non-pregnant adults age 21 or older who are aged, blind, or disabled, or relatives of Medicaid-eligible children. Enrollment in Medicaid through this Standard Spend Down program was initially capped at 105,000 enrollees.
- (2005) Effective July 1, individuals seeking to qualify for LTC benefits through eligibility track 2a (institutional rules) are able to set up a Qualified Income Trust to meet financial eligibility thresholds.
- (2006) Adult day health care, in-home respite, personal care attendant services, and assisted living services were added to the HCBS for the Elderly & Disabled program.
- (2008) On July 22, CMS approved a new set of hourly and weekly service limits to be placed on home health services for adults, replacing the 60 visit per year service limit that had been in place during this poicy period.

Overview

Long-term care (LTC) benefits in Tennessee are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Tennessee is administered at the state level by the Department of Finance and Administration, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that have different requirements, such as income and asset limits. LTC benefits in Tennessee are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based service (HCBS) LTC programs (Home and Community-Based Services for the Elderly & Disabled).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by HCBS for the Elderly & Disabled are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Those applying for HCBS for the Elderly & Disabled are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list administered on a first-come, first-serve basis.

Benefit programs vary in dependence requirements. Home Health Services require the individual to have a medical necessity for services, while Nursing Facility and HCBS for the Elderly & Disabled beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023b)

Tennessee Law for Medicaid

- Tennessee Code Annotated Section 71-2-3: Medical Care for the Aged
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Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Tennessee Medicaid spending on beneficiaries in fiscal year 2002 was 63.64%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (63.64% in 2002), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Tennessee Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Tennessee.

Eligibility for Medicaid in Tennessee for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount. In 2002, the monthly federal benefit amount was $545 for an individual and $817 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[8]
  - Citizenship/immigration requirements: The applicant must be a Tennessee resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023a) for additional information.

  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[2]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI benefit amount. In 2002 this was $1,635 for an individual. Couples are limited to $2,451 in income, but this only applies in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[6] Effective July 1, 2005, if an individual has monthly income above this threshold, they can set up a Qualified Income Trust to meet this standard (TDHS, 2008b).
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[7]
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., HCBS for the Elderly & Disabled program).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled: Effective April 30, 2005, enrollment through the Medically Needy eligibility track was closed to new enrollees except for children under age 21 and pregnant women. In 2006, this track (now called the Standard Spend Down program) was reopened to the aged, blind, and disabled population under the TennCare program (TDHS, 2008a).
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is calculated on a monthly basis and is determined by subtracting the Medicaid Protected Income Level (PIL) from net countable income over a four month period. The resulting amount must be spent on qualifying medical bills and services in order to receive Medicaid coverage for the remainder of the month. PILs vary by family size. In 2002, the PIL was $241 for an individual and $258 for a couple or household of two. This standard has remained the same since 1999.
  - Asset requirements: Same asset requirements as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[2]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include (TDHS, 2008):

- Medically eligible: Referred to as "Uninsurables" until July 1, 2002, TennCare provided Medicaid coverage for individuals who are "uninsurable" (i.e., have been turned down for health insurance due to a medical condition) with incomes up to 100% of the federal poverty level (FPL). Premiums and copayments apply if income is above the FPL. This eligibility track was closed to adults over the age of 19 starting on April 29, 2005.
- Breast and Cervical Cancer Medicaid (BCCM): Starting July 1, 2002, this eligibility track provides Medicaid coverage, including long-term care, for women who are under age 65 with income up to 250% of the FPL who have been found to have breast or cervical cancer including a precancerous condition.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Home and Community-Based Services (HCBS) for the Elderly & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 18 and eligible for Medicaid through eligibility track 2a (Institutional Rules). If the program reaches enrollment capacity, the applicant is placed on a waiting list until a

spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Program of All-Inclusive Care for the Elderly (PACE): The PACE program provides comprehensive medical and social services to some older adults still living in the community. In Tennessee, PACE was first implemented in 1999 and is only available to residents of Hamilton county.
- OPTIONS for Community Living: OPTIONS is a state-funded program providing HCBS including homemaker services, personal care, and home-delivered meals to individuals age 60 or older as well as adults age 18 or older living with disabilities.

Benefit

Home care benefit

Home Health Services

Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health visits are capped at 60 visits per year (TDFA, 2003). Starting in 2008 instead of annual service caps, nursing visits are capped at one per day and home health aide visits at two per day with a combined limit of 8 service hours per day and 35 service hours per week (TDFA, 2009).

Nursing Facility Care

Nursing Facility Care does not provide home care.

HCBS for the Elderly & Disabled

The Elderly & Disabled HCBS program provides the following services in addition to those offered under the state plan, unless otherwise noted (TDFA, 2003):

- Personal care services (PCS):
  - Assistance with activities of daily living (ADLs) such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs) such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Homemaker services: General household activities and chores such as sweeping, mopping, personal laundry, and meal preparation, as well as errands essential to the beneficiary's care such as grocery shopping or having prescriptions filled

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care.

HCBS for the Elderly & Disabled

Starting in 2006, the HCBS for the Elderly & Disabled program provides Adult Day Health Care (ADHC) services. ADHC centers provide supervision, physical and speech therapies, social services, and sometimes meals to recipients in a group setting (DFA, 2007).

Residential care

Home Health Services, HCBS for the Elderly & Disabled

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment.

Other benefits

Tennessee Medicaid provides additional state plan benefits related to LTC (TDFA, 1990; TDFA, 2003):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

HCBS for the Elderly & Disabled

The Elderly & Disabled HCBS program provides services in addition to those offered under the state plan (TCT, 2003; DFA, 2010):

- Case management
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite care: In-home and out-of-home services provided to program beneficiaries as short-term relief for the beneficiary's primary unpaid caregiver, which can be used in lieu of day, evening, or overnight care
- Home modifications: Physical adaptations, minor modifications, and the provision of equipment and monitoring systems that enhance the participant's mobility, safety, and independence in their home and community, which can include the installation of ramps and handrails; the widening of doorways; kitchen, bedroom, or bathroom modifications; or vehicle accessibility modifications
- Assistive Technology: Adaptive equipment that improves functional capabilities, such as home automation, computer accessibility software and hardware, telecare devices

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed by the Tennessee Department of Human Services and overseen by the Tennessee Department of Finance and Administration. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services must be provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provide services through state-certified home health agencies (42 CFR 484.30-36; TDFA, 2002).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (42 CFR 483.30; TDFA, 2003).

HCBS for the Elderly & Disabled

The Bureau of TennCare contracts with the Commission on Aging and Disability as the Administrative Lead Agency (ALA) responsible for program implementation and provision of services. The ALA in turn contracts with specific agencies to build county-based networks of service providers (TCT, 2003; TDFA, 2003).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. The physician must also certify that the individual is homebound, and prior authorization is required before a beneficiary can begin receiving home health services (TDFA, 1990; TDFA, 2003).

Nursing Facility Care

The beneficiary must have been a resident at a state-certified nursing facility for at least 30 days, and must meet an NFLOC by having a physician certify continuous need for nursing facility care (TDHS, 1992; TDHS, 2008b). The individual's Pre-Admission Evaluation (PAE) must demonstrate medical necessity of care, as well as the need for inpatient skilled nursing services on a daily basis. Retroactive eligibility can be approved for up to three months preceding the month of application, as long as the individual meets eligibility requirements at any time during the month (TDHS, 2003; TDFA, 2003).

HCBS for the Elderly & Disabled

The beneficiary must meet an NFLOC by having their need for skilled nursing services certified as medically necessary on their PAE. Prior to enrollment, a screening must also determine that their needs can safely be met through HCBS, and that they have a personal caretaker available during the times of day when services have been ordered in their plan of care (TDFA, 2003).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 62 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (TDFA, 2003; 42 CFR 484.55).

Nursing Facility Care

NFLOC must be recertified according to the following schedule after initial certification of the beneficiary's Pre-Admission Evaluation (TDFA, 2003):

1. 60 days after the date of initial certification
2. 180 days after the date of the initial certification
3. 12 months after the date of the initial certification
4. 18 months after the date of the initial certification
5. 24 months after the date of the initial certification
6. every 12 months thereafter

After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly & annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.128, 42 CFR 483.20).

HCBS for the Elderly & Disabled

NFLOC must be recertified according to the same schedule outlined above under Nursing Facility Care after initial certification of the beneficiary's Pre-Admission Evaluation, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (TDFA, 2003).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by the three largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

HCBS for the Elderly & Disabled

The individual must be at least age 65, or 21-64 with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary and ordered by a physician prior to receipt of services. The physician must also certify that the applicant is homebound, and that they require skilled nursing care or the services of a home health aide on an intermittent basis. To be certified as homebound the applicant must be confined to their home due to a medical condition, and only able to leave the home on brief and infrequent occasions primarily for the purposes of receiving medical care (TDFA, 2003). Medical necessity of services are documented in the applicant's plan of care as well as in supporting diagnoses of medical care needs and the physical condition of the patient, establishing that services are (TDFA, 2002):

- Consistent with the symptoms or diagnosis and treatment of the applicant's condition, disease, ailment, or injury
- Appropriate with regard to standards of good practice
- Not solely for the convenience of an applicant, physician, institution, or other provider
- The most appropriate supply or level of services which can safely be provided to the applicant

Nursing Facility Care

In order to qualify for nursing facility care, the care must be certified as medically necessary to improve or ameliorate the applicant's physical or mental condition, or to prevent a deterioration in health status. The applicant must demonstrate a need for skilled nursing facility level of care by requiring skilled nursing or rehabilitative services on a daily basis; by requiring services at greater frequency, duration, or intensity than would be provided through daily home health visits; and by being physically or mentally unable to self-administer the needed skilled services (TDFA, 2003). See Box 3 for a list of examples of skilled nursing services that may be used to certify an applicant as requiring a skilled nursing facility level of care during this policy period.

HCBS for the Elderly & Disabled

To qualify for the HCBS for the Elderly & Disabled program, the applicant must meet the same Skilled Nursing Facility Level of Care as required for admission to a nursing facility, and must have their medical, functional, and social needs determined as being able to safely be met by program services in a home-based environment. The applicant must also have one or more live-in personal caregivers unless a physican certifies that their needs can safely be met through daily but less than 24-hour caregiver services and through provision of a Personal Emergency Response System (PERS) (TDFA, 2003).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a plan of care that establishes medical need for the ordered services as well as that the individual is homebound. A home health agency may also establish a written plan of care based on verbal orders by the individual's attending physician. A registered nurse or therapist must prepare the plan of care, and submit to the physician for their signature before provision of care can begin (TDFA, 1990; TDFA, 2003).

Nursing Facility Care

A Pre Admission Evaluation (PAE) that has been approved by the Bureau of TennCare is used to certify that the individual meets a nursing facility level of care (NFLOC) by documenting medical need for skilled nursing services. The PAE must be certified by a physician, and must include a recent history and physical that support the applicant's skilled nursing needs. The nursing facility assists the individual in applying for Medicaid and qualifying for nursing facility care by coordinating the PAE with their physician, helping to complete the necessary paperwork and relevant nursing facility documentation in support of the PAE, and obtaining PAE approval through the Bureau of TennCare (TDFA, 2003).

In addition to annual PAE recertifications, nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

HCBS for the Elderly & Disabled

The HCBS for the Elderly & Disabled program uses the same PAE assessment as described above under nursing facility care to certify NFLOC and establish the individual's medical and functional needs for program services. The PAE must include a Physician Plan of Care that describes the individual's functional limitations and documents the medical necessity of services ordered. Once the individual is enrolled in the program, a comprehensive assessment of the individuals' medical and social support needs, taking

into account the medical and service needs authorized by the physician in the PAE, is conducted by the case management team to build an Individual Plan of Care that determines which program services the beneficiary requires access to (TDFA, 2003).

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (TDFA, 1990; TDFA, 2003).

Nursing Facility Care

A licensed physician must certify NFLOC and need for skilled nursing care, while the nursing facility is responsible for completing the Pre-Admission Evaluation (PAE) assessment, including coordinating with the beneficiary's physician for certification as well as submitting the PAE to the Bureau of TennCare for approval (TDFA, 2003).

HCBS for the Elderly & Disabled

A case management team comprising a case manager, a physician, a registered nurse, and a social worker is responsible for assessing the beneficiary's medical, functional, and social needs for entry into the program. The case management team oversees the development, implementation, and monitoring of the beneficiary's plan of care, and coordinates the provision of services (TDFA, 2003).

Benefit limitations

Can you mix LTC benefits?

All Tennessee Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Tennessee enforces Estate Recovery. The acceptance of Medicaid in Tennessee creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care or HCBS program services after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

Available Tennessee state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2002, the PNA was $30 per month. Effective January 1, 2005, the PNA was increased to $40 per month (TDHS, 2008b).

HCBS for the Elderly & Disabled

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2010-2024

Policy change in 2010

Starting on March 1, 2010, Tennessee began implementing the TennCare Choices in Long-Term Care (CHOICES) program, integrating preexisting long-term care (LTC) services that had been carved out and managed separately —including nursing facility care and home and community-based services (HCBS) —into TennCare, the existing statewide Medicaid managed care program. Implementation began in the Middle Tennessee region in March 2010, and expanded statewide beginning in August of the same year. Between 2010 and 2012, CHOICES comprised two groups: CHOICES: Nursing Facility Care (Group 1) for individuals receiving Medicaid-reimbursed LTC in a nursing facility, and CHOICES: HCBS (Group 2) for individuals age 65 and older and adults age 21 and older with physical disabilities who meet a nursing facility level of care (NFLOC) but who choose to receive HCBS instead of care in a nursing facility. Starting on July 1, 2012, an additional "At Risk" CHOICES: HCBS (Group 3) expansion group was added to extend HCBS services to individuals who do not meet NFLOC but who would risk institutionalization if not for the receipt of HCBS. Beneficiaries of the HCBS for the Elderly & Disabled program were absorbed into CHOICES Group 2 as the program was phased out and transitioned under TennCare (TDFA, 2024).

Other policy changes during this period:

- (2010) Effective January 1, the personal needs allowance (PNA) for nursing facility residents was increased from $40 to $50 per month (CMS, 2010).
- (2010) As of 2010, eligibility for home health services no longer requires that the beneficiary be certified as homebound (TDFA, 2008; TDFA, 2010).
- (2011) Starting in 2011 and lasting through 2016, Tennessee was awarded a Money Follows the Person grant to transition nursing home residents who are able to safely have their care needs met in a home-based environment back into their communities.
- (2016) On February 2, CMS approved Tennessee's Medicaid request to eliminate the Standard Spend Down eligibility pathway, closing eligibility track 3a to new aged, blind, and disabled enrollees.
- (2017) Effective August 7, 2017, the Bureau of TennCare was renamed the Division of TennCare (TDFA, 2021). It is still referred to as the Bureau of TennCare in certain legislative and program documents.

Overview

Long-term care (LTC) benefits in Tennessee are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Tennessee is administered at the state level by the Department of Finance and Administration, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that have different requirements, such as income and asset limits. LTC benefits in Tennessee are mostly provided through state plan benefit programs (Home Health Services), or through federally approved LTC programs (CHOICES Group 1: Nursing Facility Care, CHOICES Group 2: HCBS, and CHOICES Group 3: HCBS).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by CHOICES: HCBS are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Those applying for CHOICES: HCBS are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list administered on a first-come, first-serve basis.

Benefit programs vary in dependence requirements. Home Health Services require the individual to have a medical necessity for services, while CHOICES beneficiaries must meet either a nursing facility level of care (NFLOC) or be determined "at risk" for nursing facilitycare based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023b)

Tennessee Law for Medicaid

- Tennessee Code Annotated Section 71-2-3: Medical Care for the Aged
- Tennessee Code Annotated Section 71-5-1: Medical Assistance Act

- Tennessee Code Annotated Section 71-5-14: Long-Term Care Community Choices Act of 2008
- Tennessee Comprehensive Rules & Regulations:
  - 1200-13-01: Tennessee Department of Finance and Administration, Division of Tenncare, General Rules (TDFA, 2023)
  - 1200-13-13: Tennessee Department of Finance and Administration, Bureau of Tenncare, TennCare Medicaid (TDFA, 2011a)
  - 1200-13-16: Tennessee Department of Finance and Administration, Bureau of Tenncare, Medical Necessity (TDFA, 2011b)
  - 1240-03-02: Tennessee Department of Human Services, Division of Medical Services, Coverage Groups Under Medicaid (TDHS, 2010a)
  - 1240-03-03: Tennessee Department of Human Services, Division of Medical Services, Technical and Financial Eligibilty Requirements for Medicaid (TDHS, 2010b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Tennessee Medicaid spending on beneficiaries in fiscal year 2010 was 75.37%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (75.37% in 2010), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Tennessee Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Tennessee.

Eligibility for Medicaid in Tennessee for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount. In 2010, the monthly federal benefit amount was $674 for an individual and $1,011 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.

        - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[11]
        - Home equity limit: The equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. Beginning in 2011, this figure increases annually with inflation (TDHS, 2010b).[12]
    - Citizenship/immigration requirements: The applicant must be a Tennessee resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023a) for additional information.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[2]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
    - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI benefit amount. In 2010 this was $2,022 for an individual. Couples are limited to $3,033 in income, but this only applies in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[9] If an individual has monthly income above this threshold, they can set up a Qualified Income Trust to meet this standard.
    - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[10]
        - Asset transfer & Home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., TennCare CHOICES: HCBS).

Eligibility Track 3: Medically Needy (closed in 2016)

- 3a. Aged, blind, or disabled: In 2016, the State closed all new enrollment for this track to aged, blind, and disabled beneficiaries, after which it remained open to children and pregnant women only. Beneficiaries enrolled through this track prior to its closure were allowed to maintain coverage through the remainder of their 12-month eligibility period (CMS, 2016).
    - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is calculated on a monthly basis and is determined by subtracting the Medicaid Protected Income Level (PIL) from net countable income over a four month period. The resulting amount must be spent on qualifying medical bills and services in order to receive Medicaid coverage for the remainder of the month. PILs vary by family size. In 2010, the PIL was $241 for an individual and $258 for a couple or household of two.
    - Asset requirements: Same asset requirements as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[2]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include (TDHS, 2010a):

- Breast and Cervical Cancer Medicaid (BCCM): Provides Medicaid coverage, including long-term care, for women who are under age 65 with income up to 250% of the FPL who have been found to have breast or cervical cancer including a precancerous condition.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, CHOICES: Nursing Facility Care (Group 1)
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

CHOICES: HCBS (Group 2 and Group 3)
Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or between 21-64 with one or more disability, and eligible for Medicaid through eligibility track 2a (Institutional Rules) (TDFA, 2010). If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available.

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Money Follows the Person (MFP): From 2011 to 2016, Tennessee received federal grant funding to operate a program providing transition services to help eligible individuals living in qualified institutions move back to the community to receive care in a home-based setting.
- Program of All-Inclusive Care for the Elderly (PACE): The PACE program provides comprehensive medical and social services to some older adults still living in the community. In Tennessee, PACE was first implemented in 1999 and is only available to residents of Hamilton county.
- OPTIONS for Community Living: OPTIONS is a state-funded program providing HCBS including homemaker services, personal care, and home-delivered meals to individuals age 60 or older as well as adults age 18 or older living with disabilities.

Benefit

Home care benefit

Home Health Services
Home Health provides (TDFA, 2011):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing visits are capped at one per day and home health aide visits at two per day, with a combined limit of 8 service hours per day and 35 service hours per week (TDFA, 2011).

CHOICES: Nursing Facility Care (Group 1)
Nursing Facility Care does not provide home care.

CHOICES: HCBS (Group 2 and Group 3)[13]
TennCare CHOICES provides the following services in addition to those offered under the state plan, unless otherwise noted (DTC, 2014):

- Personal care services: capped at 2 visits per day lasting up to 4 hours per visit with at least 4 hours in between each visit
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Attendant care services: Personal care service visits lasting longer than 4 hours, available only when the beneficiary's needs cannot be met with shorter personal care visits
- Homemaker services: General household activities and chores such as sweeping, mopping, personal laundry, and meal preparation, as well as errands essential to the beneficiary's care such as grocery shopping or having prescriptions filled; as of 2012 these services are only provided as part of Personal Care Services and Attendant Care visits for those requiring hands-on assistance with ADLs

Semi-residential care

Home Health Services, CHOICES: Nursing Facility Care (Group 1)
These programs do not provide semi-residential care.

CHOICES: HCBS (Group 2 and Group 3)[13]
TennCare CHOICES provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (DTC, 2014).

Residential care

Home Health Services, CHOICES: HCBS (Group 2 and Group 3)
These programs do not provide residential care during this policy period.

CHOICES: Nursing Facility Care (Group 1)
Medicaid provides care in skilled nursing facilities (SNF), which are certified facilities providing nursing care, routine physical therapy, occupational therapy, speech pathology, room and board, and use of required equipment (TDFA, 2010).

Other benefits

Tennessee Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

CHOICES: HCBS (Group 2 and Group 3)[13]
TennCare Choices provides services in addition to those offered under the state plan (DTC, 2014):

- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Non-emergency medical transportation: Additional coverage of non-medical transportation to community services and activities
- Respite: In-home and out-of-home services provided to program beneficiaries as short-term relief for the beneficiary's primary unpaid caregiver, which can be used in lieu of day, evening, or overnight care
- Home Modification: Physical adaptations, minor modifications, and the provision of equipment and monitoring systems that enhance the participant's mobility, safety, and independence in their home and community, which can include the installation of ramps and handrails; the widening of doorways; kitchen, bedroom, or bathroom modifications; or vehicle accessibility modifications
- Assistive technology: Adaptive equipment that improves functional capabilities, such as home automation, computer accessibility software and hardware, telecare devices

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed by the Tennessee Department of Human Services and overseen by the Tennessee Department of Finance and Administration. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services
Skilled nursing services must be provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provide services through state-certified home health agencies (42 CFR 484.30-36; TDFA, 2023b).

CHOICES: Nursing Facility Care (Group 1)
Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (42 CFR 483.30; TDFA, 2023a).

CHOICES: HCBS (Group 2 and Group 3)[13]
CHOICES HCBS are coordinated and provided by regional or state-wide managed care organizations (MCOs) contracted by the Division of TennCare (TDFA, 2023a).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Prior authorization is required before a beneficiary can begin receiving home health services (TDFA, 2023).

CHOICES: Nursing Facility Care (Group 1)

The beneficiary must have been or be likely to remain a resident at a state-certified nursing facility for at least 30 days, and must meet an NFLOC by having their need for nursing facility care certified as medically necessary through obtaining a combined acuity score of at least 9 in the functional impairment and skilled and/or rehabilitative services sections of the Pre-Evaluation Assessment (PAE). See the *Definition of Dependence* section as well as Figure 1 and Table 3 for specific criteria and scoring standards used to determine a potential beneficiary's acuity score (TDHS, 2010b; TDFA, 2023a; DTC, 2020).

CHOICES: HCBS (Group 2 and Group 3)[13]

Prior to 2012, to qualify for CHOICES: HCBS, the beneficiary must meet an NFLOC by having their need for skilled nursing services certified as medically necessary on their PAE. Prior to enrollment, a screening must also determine that their needs can safely be met through HCBS, and that they have a personal caretaker available during the times of day when services have been ordered in their plan of care (TDFA, 2010).

Starting on July 1, 2012, to qualify for CHOICES: HCBS an individual must meet one of the following level of care criteria:

- To qualify for HCBS in Group 2, the beneficiary must meet NFLOC by having their need for nursing facility care certified as medically necessary, as well as by obtaining a combined acuity score of at least 9 in the functional impairment and skilled and/or rehabilitative services sections of the Pre-Evaluation Assessment (PAE). See the *Definition of Dependence* section as well as Figure 1 and Table 3 for specific criteria and scoring standards used to determine a potential beneficiary's acuity score.
- To qualify for HCBS in Group 3, the beneficiary must be at risk of requiring NFLOC by requiring assistance daily or at least 4 days per week in an ADL or ADL-related function. See the *Definition of Dependence* section for more information, as well as Box 4 for a list and descriptions of ADL and ADL-related functions assessed to satisfy NFLOC and at-risk criteria (TDFA, 2023a; TDTC, 2020).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 62 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (TDFA, 2023a; 42 CFR 484.55).

CHOICES: Nursing Facility Care (Group 1)

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (DTC, 2020). After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (42 CFR 483.128), and federally required quarterly & annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20).

CHOICES: HCBS (Group 2 and Group 3)[13]
NFLOC and "at risk" level of care requirements must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (DTC, 2020).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by the three largest programs.

Medicaid
There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, CHOICES: Nursing Facility Care (Group 1)
There is no age requirement.

CHOICES: HCBS (Group 2 and Group 3)[13]
The individual must be at least age 65, or 21-64 with a physical disability.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services
Home health services must be medically necessary and ordered by a physician prior to receipt of services (TDFA, 2023b). To be medically necessary, a service must be required in order to treat a medical condition, it must be safe and effective, it must be the least costly alternative course of treatment adequate for the medical condition of the beneficiary, and it cannot be an experimental or investigational treatment (TCA, 2023).

CHOICES: Nursing Facility Care (Group 1)
In order to qualify for CHOICES: Nursing Facility Care, the applicant must meet nursing facility level of care (NFLOC), meaning they require the amount and type of care one would receive in a nursing home 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 (TDT, 2020). Prior to 2012, NFLOC was certified on the beneficiary's Pre Admission Evaluation (PAE) assessment through documentation supporting the beneficiary's medical need for skilled nursing services (TDFA, 2010).

After 2012, in order to meet NFLOC the individual must be unable to self-perform needed nursing care and must have difficulty with at least two out of eight activities of daily living (ADLs) and ADL-related functions or require skilled or rehabilitative services such that they score at least a 9 out of a possible 26 on the TennCare NFLOC Acuity Scale (TDFA, 2023a). See Figure 1 for the scoring matrix for acuity scales in ADLs and ADL-related activities, see Box 5 for how to interpret each score, and see Table 3 for the scores ascribed to the need for individual skilled or rehabilitative services.

CHOICES: HCBS (Group 2 and Group 3)[13]
There are two levels of dependence that can qualify an applicant for home and community-based services through TennCare's CHOICES program (CHOICES Groups 2 and 3). To qualify for CHOICES Group 2, the applicant must meet NFLOC, which for HCBS means they require services to allow them to continue living safely in the community and delay or prevent placement in a nursing facility (TDT, 2020). They must satisfy the same criteria as CHOICES Group 1 (nursing facility care) beneficiaries by scoring at least 9 out of 26 on the NFLOC Acuity Scale, and must be determined through an approved Safety Determination Request to not be able to be safely served within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3 (TDFA, 2023a).

To qualify for CHOICES Group 3, the applicant must be ineligible to receive care in a nursing facility (i.e. they do not meet NFLOC) but must be at risk of nursing facility placement if not for receipt of HCBS. They must have a physical or mental condition, disability, or impairment that requires ongoing supervision or assistance with ADLs in the home or community setting, they must be unable

to self-perform needed nursing care, and must have a significant deficit in an ADL or ADL-related function, defined as requiring assistance at least 4 times weekly (TDT, 2020; TDFA, 2023a).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a plan of care that establishes medical need for the ordered services. Prior authorization must be obtained from a physician before managed care contractors can establish medical necessity and deliver services (TDFA, 2023b).

CHOICES: Nursing Facility Care (Group 1)

Until 2012, a Pre Admission Evaluation (PAE) that has been approved by the Bureau of TennCare is used to certify that the individual meets a nursing facility level of care (NFLOC) by documenting medical need for skilled nursing services. The PAE must be certified by a physician and must include a recent history and physical that support the applicant's skilled nursing needs. The nursing facility assists the individual in applying for Medicaid and qualifying for nursing facility care by coordinating the PAE with their physician, helping to complete the necessary paperwork and relevant nursing facility documentation in support of the PAE, and obtaining PAE approval through the Bureau of TennCare (TDFA, 2010).

Effective July 1, 2012, a new set of NFLOC criteria were implemented along with a standardized PAE form designed to evaluate the specific functional and medical needs used to determine the individual's acuity score according to the new criteria. The individual must have difficulty with the following ADLs and ADL-related activities:

- Transfer
- Mobility
- Eating
- Toileting
- Communication (expressive and receptive)
- Orientation (to person, place, or event/situation)
- Behaviors
- Self-administration of medications

And/or must require the following skilled or rehabilitative services:

- Ventilator use
- Tracheostomy
- Total parenteral nutrition or tube feeding
- Complex wound care, or wound care for stage 3 or 4 decubitus
- Peritoneal dialysis
- Intravenous fluid administration
- Injections (insulin or other IV)
- Isolation precautions
- PCA pump
- Occupational or physical therapy

Acuity scores are determined based on how the applicant satisfies criteria in the Pre-Admission Evaluation (PAE) assessment form as completed by a physician or registered nurse, and diagnoses must be supported by medical evidence. See TBT (2023) for the PAE form and see Figure 1 for the scoring matrix for acuity scales in ADLs and ADL-related activities, see Box 5 for how to interpret each score, and see Table 3 for the scores ascribed to the need for skilled or rehabilitative services.

In addition to annual PAE recertifications, nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

CHOICES: HCBS (Group 2 and Group 3)[13]

The TennCare CHOICES program uses the same PAE assessment as described above under nursing facility care to certify NFLOC and establish the individual's medical and functional needs for HCBS. Between 2010-2012, the individual's physician must certify on a PAE approved by the Bureau of TennCare that they meet NFLOC by documenting their medical need for skilled nursing services, and a managed care organization (MCO) must authorize the PAE prior to the delivery of services. Beginning in 2012 the newly standardized PAE form and NFLOC criteria are used to determine whether individuals qualify for HCBS. To qualify for CHOICES:

HCBS Group 2, the beneficiary must score at least 9 out of a possible 26 on the TennCare NFLOC Acuity Scale, and must also have a Safety Determination state that their needs cannot safely be met through services available to "At Risk" CHOICES: HCBS Group 3. While there are no specific criteria to be met for approval of a Safety Determination, the Division of TennCare requires the following materials for consideration (TDT, 2020):

- A completed PAE
- An assessment of the applicant's physical, behavioral, and psychosocial needs not reflected in the PAE, including the specific tasks and functions for which assistance is needed by the applicant, the frequency with which such tasks must be performed, and the applicant's need for safety monitoring and supervision
- The applicant's living arrangements and the services and supports they have received for 6 months prior to submission of the Safety Determination Request, including unpaid care provided by family and paid services
- A detailed explanation regarding any recent significant events or circumstances that have impacted the applicant's need for services and supports

To qualify for CHOICES: HCBS Group 3, the beneficiary does not need to satisfy a specific acuity score, but must have a significant deficit in an ADL or ADL-related function supported by a medical diagnosis documented on their PAE such that they require assistance daily or at least four times weekly (TDT, 2020).

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (TDFA, 2023a).

CHOICES: Nursing Facility Care (Group 1)

A licensed physician must certify NFLOC and need for skilled nursing care, and while a range of TennCare partners can conduct complete the Pre-Admission Evaluation (PAE) assessment, typically the nursing facility completes and submits the PAE to the Division of TennCare for approval (TDT, 2020).

CHOICES: HCBS (Group 2 and Group 3)[13]

For potential TennCare CHOICES HCBS beneficiaries, the PAE assessment can be conducted by a range of organizations including managed care organizations (MCOs), Area Agencies on Aging and Disability (AAADs), nursing homes, and hospitals. A physician must certify the medical necessity of services ordered through the plan of care on the PAE. For CHOICES applicants who are already enrolled in Medicaid, MCOs perform intake functions, including completion and submission of the PAE to the Division of TennCare. For CHOICES applicants who are not yet enrolled in Medicaid and who seek HCBS, AAADs are designated as a single point of entry into the program and are contracted by TennCare to complete and submit PAE assessments (TDT, 2020).

Benefit limitations

Can you mix LTC benefits?

All Tennessee Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Tennessee enforces Estate Recovery. The acceptance of Medicaid in Tennessee creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care or HCBS program services after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

Available Tennessee state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

CHOICES: Nursing Facility Care (Group 1)

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2010, the PNA was $50 per month.

CHOICES: HCBS (Group 2 and Group 3)[13]

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Tennessee Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	68.41%
1993	67.57
1994	67.15
1995	66.52
1996	65.64
1997	64.58
1998	63.36
1999	63.09
2000	63.10
2001	63.79
2002	63.64
2003	66.07
2004	66.76
2005	64.81
2006	63.99
2007	63.65
2008	63.71
2009	73.74
2010	75.37
2011	71.22
2012	66.36
2013	66.13
2014	65.29
2015	64.99
2016	65.05
2017	64.96
2018	65.82
2019	65.87
2020	69.86
2021	72.30
2022	72.56
2023[1]	71.08
2024	65.66

Source: U.S. DHHS (2024)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201).

[1]The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Historical Tennessee Medicaid Income Limits

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)
1992	$422	$633	$1,266	$1,899
1993	434	652	1,302	1,956
1994	446	669	1,338	2,007
1995	458	687	1,374	2,061
1996	470	705	1,410	2,115
1997	484	726	1,452	2,178
1998	494	741	1,482	2,223
1999	500	751	1,500	2,253
2000	513	769	1,539	2,307
2001	531	796	1,593	2,388
2002	545	817	1,635	2,451
2003	552	829	1,656	2,487
2004	564	846	1,692	2,538
2005	579	869	1,737	2,607
2006	603	904	1,809	2,712
2007	623	934	1,869	2,802
2008	637	956	1,911	2,868
2009	674	1,011	2,022	3,033
2010	674	1,011	2,022	3,033
2011	674	1,011	2,022	3,033
2012	698	1,048	2,094	3,144
2013	710	1,066	2,130	3,198
2014	721	1,082	2,163	3,246
2015	733	1,100	2,199	3,300
2016	733	1,100	2,199	3,300
2017	735	1,103	2,205	3,309
2018	750	1,125	2,250	3,375
2019	771	1,157	2,313	3,471
2020	783	1,175	2,349	3,525
2021	794	1,191	2,382	3,573
2022	841	1,261	2,523	3,783
2023	914	1,371	2,742	4,113
2024	943	1,415	2,829	4,245

Source: SSA (2024)
Notes: Supplemental Security Income (SSI) amounts for individuals and couples are monthly.

Box 1: Preadmission Screening and Resident Review (PASARR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASARR). The purpose of the PASARR is to rpevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level I screening), and a final determination. All applicants of Medicaid-certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASARR evaluation.

Source: 42 CFR 483.100-138

Box 2: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: CMS (2023b)

Box 3: Examples of Skilled Nursing Services to Qualify for NFLOC (2000-2012)

Examples of skilled nursing services that, if required on a daily basis, may qualify an individual for skilled nursing facility level of care include but are not limited to the following:

- Gastrostomy tube feeding
- Sterile dressings for Stage 3 or 4 pressure sores
- Total parenteral nutrition
- Intravenous fluid administration
- Nasopharyngeal and tracheostomy suctioning
- Ventilator services

Source: TDFA (2003)

Figure 1: TennCare Acuity Scale for ADLs and ADL-related Functions (2012-2024)

ADL (or related) Question	Always	Usually	Usually not	Never	Maximum Individual Acuity Score	Condition	Maximum Acuity Score for the Measure(s)
Transfer	0	1	3	4	4	Highest value of the two measures	4
Mobility	0	1	2	3	3		
Eating	0	1	3	4	4		4
Toileting	0	0	1	2	2	Highest value of three questions for toileting measure	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	0	0	0	1	1	Highest value of two questions for communication measure	1
Receptive communication	0	0	0	1	1		
Self-administration of medication	0	0	1	2	2		2
Behavior	3	2	1	0	3		3
Maximum possible ADL (or related) Acuity Score							21

Source: TDFA (2023a)

Notes: Scores represent the weighted values representing the beneficiary's independence or deficiency in these Activities of Daily Living (ADLs) and ADL-related functions. Questions on the Pre-Admission Evaluation form are used to assess each of these measures, and the cumulative score (out of a maximum of 21) is calculated based on the scoring matrix above.

Table 3: TennCare Acuity Scale for Skilled or Rehabilitative Services (2012-2024)

Skilled or Rehabilitative Service	Maximum Individual Acuity Score
Ventilator	5
Frequent tracheal suctioning	4
New or old tracheostomy	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	1
Physical therapy	1
Teaching catheter/ostomy care	0
Teaching self-injection	0
Other	0
Maximum Possible Skilled Services Total Acuity Score	5

Source: TDFA (2023a)

Notes: Scores are the weighted values for each service that needed at a level required to qualify for care in a nursing home, i.e. required on a daily basis or at least five days per week for rehabilitative services.

Box 4: ADL and ADL-Related Functional Deficits for CHOICES Group 3 (2012-2024)

- Transfer: The Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or at least four days per week). Approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of transfer assistance required.
- Mobility: The Applicant requires physical assistance from another person for mobility on an ongoing basis (daily or at least four 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 (manual or electric) if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement. Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.
- Eating: The Applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging) 4 or more days per week to consume prepared food and drink (or self administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement. Approval of this deficit shall require documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task.
- Toileting: The Applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or catheter care on an ongoing basis (daily or at least four days per week). Approval of this deficit shall require documentation of the specific type and frequency of toileting assistance required.
- Communication (Expressive and Receptive): The Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices; or the Applicant is incapable of understanding and following very simple instructions and commands without continual intervention (daily or at least four days per week). Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.
- Orientation: The Applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm) daily or at least four days per week. Approval of this deficit shall require documentation of the specific orientation deficit(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the Applicant.
- Medication Administration: The Applicant is not cognitively or physically capable (daily or at least four days per week) of self-administering prescribed medications at the prescribed schedule 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 Applicant, reassurance of the correct dose, and the use of assistive devices including a prepared medication box.
- Behavior: The Applicant requires persistent staff or caregiver intervention and supervision (daily or at least four days per week) due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the Applicant or others at imminent and serious risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care, intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost). Approval of this deficit shall require documentation of the specific behaviors and the frequency of such behaviors.
- Skilled Nursing or Rehabilitative Services: The Applicant requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through daily home health visits. Approval of such skilled nursing or rehabilitative services shall require a physician's order and other documentation as specified in the Pre-Admission Evaluation form.

Source: TDFA (2023a)

Box 5: TennCare Acuity Scale for ADLs and ADL-Related Functions: Scoring Interpretation (2012-2024)

Interpretation of possibile responses for all measures except behavior:

- Always: always independent with that ADL or related activity
- Usually: requires assistance fewer than 4 days per week
- Usually not: requires assistance 4 or more days per week
- Never: never independent with that ADL or related activity

Interpretation of possible responses for the behavior measure:

- Always: always requires intervention for dementia-related behaviors
- Usually: requires intervention for dementia-related behaviors 4 or more days per week
- Usually not: requires intervention for dementia-related behaviors, but fewer than 4 days per week
- Never: does not have dementia-related behaviors that require intervention

Source: TDFA (2023a)

Sources

This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/policy-explorer).

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Administrative Lead Agency (ALA): The Commission on Aging and Disability, or the agency contracted with by the Bureau of TennCare to provide services covered by the Home and Community-Based Services for the Elderly and Disabled program.

Adult Day Health Care (ADHC): ADHC is a community-based long term care benefit that provides nursing care, personal care, social, nutritional, and therapeutic services, typically furnished in a community center for four or more hours per day at least once per week.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Alternate Living Services (ALS): ALS homes provide 24-hour supervision with access to medically related personal care, nursing services, physical/occupational/speech therapies, dietitians, and meal services to individuals unable to continue living independently at home. Residents are responsible for covering room and board.

Area Agencies on Aging and Disability (AAAD): Area Agencies on Aging are a nationwide network of public or private non-profit agencies designated by each state to carry out a range of functions including advocacy, service provision, and the coordination of community-based systems serving vulnerable older adults in each planning and service area as mandated by the Older Americans Act. In Tennessee, there are nine Area Agencies on Aging and Disability (AAAD) that plan and provide programs and services for older adults and disabled residents in their service areas. For individuals seeking home and community-based services through the CHOICES program, AAADs are the designated single point of entry into the program and are contracted by TennCare to conduct intake assessments.

Bureau of TennCare: Division within the Tennessee Department of Finance and Administration responsible for administering the TennCare program. Effective August 7, 2017, the Bureau of TennCare was renamed the Division of TennCare.

Centers for Medicare and Medicaid Services (CMS): Federal agency within the US Department of Health and Human Services responsible for administering the Medicaid and Medicare programs.

CHOICES Group 1: TennCare CHOICES Group 1 covers beneficiaries of all ages who receive care in a state-certified nursing home.

CHOICES Group 2: TennCare CHOICES Group 2 covers older adults as well as individuals age 21 and older with physical disabilities who qualify to receive nursing facility level of care (NFLOC) but who choose to receive home and community-based services instead.

CHOICES Group 3: TennCare CHOICES Group 3 covers older adults as well as individuals age 21 and older who do not qualify for a nursing facility level of care (NFLOC), but who are at risk of institutionalization and require home and community-based services to delay or prevent the need for nursing home care.

Commission on Aging and Disability (CAD): The designated state agency on aging, contracted by the Bureau of TennCare between 2002-2010 to administer the state Home and Community-Based Services for the Elderly and Disabled program.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Department of Finance and Administration: The single state agency designated to administer and operate the state's Medicaid program.

Department of Human Services: Tennessee department that determines financial eligibility for Medicaid.

Home and Community-Based Services for the Elderly and Disabled: HCBS for the Elderly and Disabled was Tennessee's program providing home and community-based long-term care services to Medicaid beneficiaries on a fee-for-service basis between 2002 and 2010.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP for medical assistance is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent).

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Services provided in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as anbadult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Homebound: An individual is considered homebound if they have a condition due to illness or injury that makes leaving the home medically inadvisable.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Managed care organization (MCO): Health plans that administer Medicaid services and contract with providers to deliver services. MCOs receive a capitated per member per month fee from the state and reimburse providers for services enrollees receive.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid state plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway. Tennessee closed this eligibility pathway to new enrollees except pregnant women and children under age 21 effective April 30, 2005, and between 2006-2016, it implemented a Standard Spend Down program effectively reopening this eligibility pathway to a limited number of aged, blind, and disabled individuals with the same medically needy spend-down limits.

Medicare: Federal health insurance program for people ages 65 and over, as well as certain people under 65 with a long-term disability, that helps pay for medical care services regardless of income, medical history, or health status. Medicare covers skilled nursing facility stays and some home health visits, but benefits are subject to a deductible and do not cover extended home health visits required for long-term care needs.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Money Follows the Person (MFP): MFP is a federal grant program supporting states in rebalancing their long-term care services, and provides funds to transition Medicaid beneficiaries from institutional care back into their communities.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation

needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing Facility Level of Care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care.

OPTIONS for Community Living: A state-funded program providing home and community-based care (HCBS) to the elderly as well as to adults with disabilities.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Permanently Residing Under Color of Law (PRUCOL): An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Emergency Response System (PERS): Electronic devices (e.g., portable "help" buttons connected to the Enrollee's telephone and monitored by response centers) that enable beneficiaries who are alone for significant parts of the day and who would otherwise require extensive routine supervision to secure help in an emergency.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Pre Admission Evaluation (PAE): A state-approved evaluation assessment conducted prior to entry into either nursing facility care, or into a Medicaid or TennCare home and community-based services (HCBS) program. The evaluation establishes the level of care needed for entry into a nursing facility or home-based care program, as well as the medical necessity of services ordered in the beneficiary's plan of care.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utiliztion review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

Private Duty Nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent.

Program of All-Inclusive Care for the Elderly: A federally authorized program that provides comprehensive medical and social services to elderly individuals requiring a nursing facility level of care. PACE programs are typically provided under Medicare, however states can elect to provide PACE services to Medicaid beneficiaries as an optional benefit. Enrollment in PACE programs is typically capped at a relatively low number of participatns.

Protected Income Level (PIL): The income limit Medically Needy applicants must spend down to meet. Federal rules require PILs to be

no higher than 133 percent of the maximum state Aid to Families and Dependent Children (AFDC) level in effect as of July 16, 1996.

Qualified Income Trust (QIT): A Qualified Income Trust (QIT), or Miller Trust, is an irrevocable trust that allows individuals with excess income to qualify for Medicaid benefits. Each month, the beneficiary's excess income is deposited in the QIT, and a designated trustee can use these funds for limited purposes that include the beneficiary's monthly personal needs allowance, residential care facility costs, community spouse allocations, and any other care-related expenses. When the beneficiary passes away, any remaining funds in the account are claimed by the State.

Respite care: Services provided to participants who are unable to care for themselves, furnished on a short-term basis because of the absence or need of relief for those persons normally providing care for the participant.

Section 1115 Waiver: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

Section 1915(c) Waiver: Section 1915(c) of the Social Security Act gives the Secretary of HHS the authority to approve programs allowing states to offer home- and community-based services to Medicaid beneficiaries who need long-term care and who would otherwise be institutionalized. The program waives Medicaid comparability requirements, meaning that states can tailor the services to specific groups of enrollees and their needs.

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Disability Insurance (SSDI) : Federal program providing cash assistance to Americans with disabilities and qualifying work history, as determined by the Social Security Administration.

Spend down: Spend down, typically associated with the medically needy Medicaid eligibility pathway, is a mechanism through which individuals with excess income qualify for Medicaid by spending down their excess income in the form of qualifying expenses, including medical bills and related expenses that are not covered by health insurance. Starting in 2005 Tennessee started to allow aged, blind, and disabled individuals seeking nursing facility or home and community-based services to spend down to track 2a income limits.

Standard Spend Down (SSD): Between 2006 and 2016, while the medically needy eligibility pathway was closed to all new enrollees except for pregnant women and children, Tennessee implemented a separate Medicaid program called Standard Spend Down (SSD) that extended Medicaid coverage to aged, blind, and disabled individuals subject to the same medically needy monthly spend down limits. Enrollment in SSD was capped at a specific number each enrollment period, with beneficiaries admitted on a first-come first-serve basis.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

TennCare: TennCare is the name for Tennessee's Medicaid program. Implemented in 1994, it is one of the oldest Medicaid managed care programs in the country. Initially LTC services such as nursing facility care and home and community-based services were "carved out" of TennCare and administered separately as fee-for-service programs, and in 2010 they were integrated into TennCare as the TennCare CHOICES in Long-Term Care program.

TennCare CHOICES in Long-Term Care (CHOICES): A TennCare program that provides older adults and adults with physical disabilities who require the level of care typically provided in a nursing facility or who are at risk of moving into a nursing facility with a range of long-term care services. CHOICES offers home and community-based services (HCBS) to assist individuals with activities of daily living, as well as care in a nursing facility as an alternative to HCBS. CHOICES members are assigned to one of three groups: Group 1 for people receiving nursing facility care, Group 2 for adults who qualify to receive nursing facility care but who choose to receive home care services instead, and Group 3 for adults who don't qualify for nursing facility care but who are at risk of moving into one and who need home care

services to delay or prevent the need for nursing facility care.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, insome circumstances, to their sibling or adult child (KFF, 1999).

2. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).

3. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023) for more information on these requirements.

4. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. In Tennessee, the community spouse is entitled a Monthly Maintenance Needs Allowance (MMNA) based on 150 percent of the federal poverty limit for two people, which was $1,149 in 1992.

5. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $13,740-$68,700 in 1992. In Tennessee, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.

6. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. In Tennessee, the community spouse is entitled a Monthly Maintenance Needs Allowance (MMNA) based on 150 percent of the federal poverty limit for two people, which was $1,493 in 2002. Authors were unable to verify whether Tennessee extended spousal impoverishment rules to the HCBS for the Elderly and Disabled program during this time.

7. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $17,856-$89,280 in 2002. In Tennessee, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.

8. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999). In 2006, the Deficit Reduction Act extended the look back period to 60 months for all assets.

9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. In Tennessee, the community spouse is entitled a Monthly Maintenance Needs Allowance (MMNA) based on 150 percent of the federal poverty limit for two people, which was $1,821 in 2010. From 2014, the ACA required all states to extend spousal impoverishment rules to individuals receiving HCBS.

10. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $21,912-$109,560 in 2010. In Tennessee, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if

this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.

11. The look back period is 60 months prior to the date of application for all assets.
12. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
13. While TennCare CHOICES is structured as one three-pronged program providing LTC benefits to three different groups of TennCare beneficiaries, Groups 2 and 3 have access to the same home and community-based service (HCBS) benefits so are treated as one program throughout this document to facilitate comparison with other state and national LTC benefit programs.

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- 1.0 (March 2024): First version.