Service Provider (other than DSP)	Page 4

Regarding ""“In order to be eligible for this waiver, the person must require a program of specialized services and but for the provision of those services, require the level of care provided in an ICF/IID. Accordingly, a person must RECEIVE at least one ongoing waiver service in addition to independent support coordination on an ongoing basis—at a minimum, quarterly.”

- A major issue with this is that it's not that individuals CHOOSE to receive or not receive services; it's that there are not enough providers and services in a large part of Tennessee in the rural areas so it is very often challenging 1) FINDING supports, agencies and providers in general 2) Finding supports that have enough staff 3) Finding consistent supports 4) Finding supports that offer a full range of services 5) Finding qualified supports and keeping them consistently 6) Finding a good fit for staff.....these issues appear to have worsened following COVID so changing the language would NOT benefit individuals in circumstances and in fact, could discriminate against them when they are not able to control the environment or circumstances that impact supports/services

In addition, on page 5, the proposed change "As part of proposed amendments to integrate and transform programs and services for individuals with I/DD, HCBS provided under this waiver will become part of the managed care program. Each waiver participant’s currently assigned Managed Care Organization (MCO)— already charged with administering their physical and behavioral health benefits—will also administer their waiver services under the day-to-day operational leadership, management, and oversight of DIDD”.

This is a concern because MCO's and their care coordinators may not understand the dynamics of the actual resources in the areas available - a 'list of providers' does not necessarily mean that there are ACTUALLY providers in that area, that consistent services or staff have been available, nor that families have access to them. There are also a number of reasons progress on outcomes is sometimes interrupted and oversight may prohibit direct communication about some of these person-centered, specific issues in the focus on relying on MCO individuals whose main function is to assess efficiency and progress on outcomes as a way to measure use of funds. Case managers have developed relationships with families and support their growth through problem-solving some of these issues and developing additional strategies in supporting the family as a whole to enhance the progress and wellbeing of the individual served; it's important these relationships continue to assist in achieving effective outcomes through services available and provided consistently. The concern would be that moving away from a personalized relationship with one individual and having MCO's make the decisions would indicate previous CM's have not been effective and efficient at managing this partnership with the MCO; in addition, it would remove some of the benefit seen when CM's work with providers and agency, noting influence often comes with the position of being able to determine if the programs are meeting the person-centered specific needs of individuals. It would essentially undermine current CM's ability to support families in best practice and could move more towards a less person-centered practice of individuals who only know service recipients by name and paperwork into making decisions that they feel are best based on the limited knowledge they have in front of them in a computer rather than the reality of what the service area, providers, staff, family needs, etc. are. It will also require increased certifications and additional paperwork that is time consuming; possibly moving in a direction of renewed authorizations more frequently and increased 'red tape' before an individual can receive needed supports/services - often this can result in an actual loss of service as someone else 'takes the spot' while the individual is waiting for approval. It assumes CMs are 'in office' workers and available to follow up with all types of forms and documents when in

reality, the intention and most effective parts of a CM's relationship with family are in person - where they can observe issues, see any challenges, ask questions triggered by things observed, etc.

"MCOs will not be obligated to contract with all providers deemed as credentialed but can select from deemed providers using a set of person-centered “preferred” contracting standards and/or quality performance indicators adopted by TennCare and DIDD. MCOs will be responsible for ensuring an adequate network of providers who are qualified to deliver high quality services, including the achievement of individual and system outcomes. MCOs will coordinate with TennCare, DIDD, providers and other stakeholders to define and refine these standards on an ongoing basis and will support contracted providers in building capacity to deliver high quality services, including the achievement of individual and system outcomes. This means that a provider could be “deemed” by DIDD to meet credentialing standards, but not selected by any MCO for network participation." - Will there be an appeal process for providers who an individual may prefer, and does this affect their freedom of choice?

How is the long timeframe (120 days) for an MCO to respond to provider billing going to impact a provider's services - shouldn't this be a shorter turnaround, such as 90 days? Many are not in a financial position to 'float' a longer timeframe.

"TennCare contracts with MCOs that provide physical, behavioral, and beginning July 1, 2021, HCBS to waiver participants. TennCare will not pay a monthly capitated payment per eligible enrollee for HCBS provided pursuant to this waiver. Rather, TennCare will reimburse the MCO for the actual cost of 1915(c) waiver HCBS, in order to develop sufficient experience for purposes of establishing an actuarially sound capitation rate for 1915(c) waiver HCBS. These actual costs of 1915(c) waiver HCBS will be reflected in the MMIS through 837 encounter files submitted by the MCO to TennCare.
" Concern is that this will NOT be an accurate reflection as again, most services have not yet recovered and are not providing 100% of the needed supports individuals in the waivers need and would benefit from - they are still 'limping' after COVID and staffing issues have affected their ability to provide these supports - thus numbers been assessed are not accurate and may be setting a lower rate than what the actual cost is when the program is fully functioning. An example is that one gentleman I support has been waiting over a year to have a local job coordinator that can assist him in finding a new job (Because of the staffing issues, the required training for the individuals in the role and the amount of time it takes for them to achieve it, the economy and how the gentleman's previous job - which he worked for 20 years - dissolved due to COVID). This is WITH the support of vocational rehabilitation, and he still has not been able to work with a job coordinator in his area, much less find a job coach that can consistently provide him with supports in learning a new job and moving to stabilization.

Why would this be removed? It seems contraindicated to what Person-Centered planning is when you remove this language and focus instead on the MCO's role of increasing a focus on health and wellness, their impact on planning, etc. " (Information for the ISPPCSP will be gathered and developed through the person-centered planning process driven, to the greatest extent possible, by the person supported and, if applicable, in collaboration with the guardian or conservator, as well as family members and other persons specified by the person supported.);"

Thank you for your comments.

The waivers have indicated for some time that in order to remain eligible for the waiver, the person must need at least one service in addition to Support Coordination/Case Management on an ongoing

basis, at a minimum, quarterly. The state is proposing this change to further clarify this federal requirement that members enrolled continue to need ICF/IID level of care and would, but for the provision of the waiver services, otherwise be institutionalized in an ICF/IID. We are aware that some waiver participants experience lapses in service due to various reasons outside of one's control, including staffing shortages, lack of willing/able providers, and more recently, the COVID-19 pandemic. **Members will not be involuntarily disenrolled from the waiver under these circumstances.** However, there are also instances of waiver recipients not receiving services due to refusal of services or refusal to comply with waiver service requirements. TennCare and DIDD currently review and will continue to review and investigate all applicable lapses in waiver services on an individual basis before moving forward with actions to involuntarily disenroll someone from a waiver. All notices of involuntary disenrollment will be accompanied by appeal rights. [42 CFR 435.217, 42 CFR 441.302]

Our plan for transitioning the 1915(c) waivers into managed care is focused on maintaining and elevating person-centered values within the person-centered planning process. In fact, a major change proposed within this renewal and the accompanying amendments involves person-centered updates in Support Coordination processes and expectations. **With this renewal and amendments, waiver members will not lose their Independent Support Coordinators (ISCs)/DIDD Case Managers (CMs).** Waiver participants' ISCs and DIDD CMs will continue to facilitate the person-centered planning process and evaluation of 1915(c) waiver supports and will maintain their relationships with waiver participants and their support networks.

There will not be an appeal process for credentialing/re-credentialing. As of July 1, 2022, new 1915(c), Katie Beckett Part B, and ECF CHOICES providers are credentialed by DIDD using standards consistent with waiver provider qualifications, contract requirements, and National Committee for Quality Assurance (NCQA) standards. These standards were also established in partnership with DIDD and MCOs, with input from I/DD stakeholders. Providers will be periodically re-credentialed by DIDD using these collaborative standards. Both DIDD and the MCOs will have responsibility to ensure adequacy of the provider network. MCOs will be obligated to contract with all 1915(c) providers "deemed" by DIDD to continue the seamless delivery of current services as specified in each person's approved Individual Support Plan, without gaps in care for at least the first six (6) months following implementation of the integrated I/DD system, or the remainder of their ISP year, whichever is later. This requirement will minimize potential disruptions in care, allow time for effective person-centered planning, and facilitate transition to another provider selected by the person if the current provider will no longer be part of the MCO's network once the continuity of care period has expired. Beyond that period, the MCOs will have the flexibility to build their provider networks at their discretion. This will not affect the person's freedom of choice because they are unable to choose to receive services from an out of network provider. However, they could choose to change MCOs if another provider has contracted with a preferred provider. As part of the managed care program, individuals will continue to select their choice of provider from among those contracted with their MCO that is willing and available to initiate services timely and to consistently provide services in accordance with the PCSP. The person is not entitled to receive services from a particular provider or to a fair hearing if he is not able to receive services from the provider of his choice.

To bring the 1915(c) waivers under managed care, payment for services will transition from DIDD to the MCOs with approval of the renewal and amendments, which means that the timely filing period for 1915(c) waiver claims must align with other HCBS programs. Many providers of other HCBS

programs also provide 1915(c) waiver services and we hope this alignment will reduce administrative burden for providers. We understand the importance of provider payments and are working to ensure that sufficient planning and communication will occur prior to the transition of billing and payment processes to the MCOs.

As with all TennCare populations and as required under federal regulations, when MCOs are "at risk," MCOs must be paid an actuarially sound capitation rate based on the populations served and the services required under the contract. The MCOs are then required to provide all medically necessary services in accordance with the member's plan of care, including services for those with the highest levels of need. As it relates to HCBS services for individuals with intellectual disabilities, the state does not intend to utilize a capitation (or risk)-based payment at this juncture. Using flexibility provided under federal regulations, MCOs will be reimbursed for the services they provide, similar to the Employment and Community First CHOICES program. The state will continue to evaluate the payment approach going forward and should a risk-based payment approach be adopted in the future, will establish actuarially sound rates, with sufficient checks and balances to ensure that individuals continue to receive the services they need to live successfully in the community and achieve their individualized goals.

We removed this language because it is duplicative of language included throughout the Service Plan Development section, which indicates that the person-centered planning process, including PCSP development, is directed by the person, involves coordination with the MCO regarding the person's physical and behavioral health care needs and goals, and the person's needs, preferences, and goals are identified and included in the person's PCSP as part of this process.

Independent Support Coordinator (ISC) or Case Manager (CM)	Page 69

I propose in the SDW, there should only be a home visit conducted once a year. Agency visits or alternative location visits should be conducted quarterly. Most people that attend an agency don't receive services in the home, so it's not clear why home visits must be conducted. There was an incident where a CM was conducting 4 home visits in a rural area during a winter month at night because the people didn't return home from the agency until after 3pm, which made the last visit at 5pm. The CM had a 1 1/2-hour drive back to the office. On the way back to the office the CM was almost in a serious accident on a 2-lane road, with no streetlights. I believe home visits can be conducted during the summer months in the daylight which is much safer. This has been a concern for many CM's and this requirement needs to change. I believe we need to be safe when traveling and not be placed in hazardous situations.

Thank you for your comment.

The ISP/PCSP (Individual Support Plan/Person Centered Support Plan) is the fundamental tool by which the state ensures the health and welfare of the individuals served under this waiver. As such, it is subject to periodic review and update. These reviews which can be conducted (as outlined below) by telephone, in person or virtually) **are to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the person's disability and are responsive to the person's needs and preferences.** Many people receiving Self-Determination Waiver (SDW) services receive services in their home and don't have a provider agency. There is flexibility in the waiver language that allows for the person to receive a visit in the person's home or in alternate locations as chosen by the person or the person's family. A DIDD

Case Manger can work around a person's schedule and conduct the visits as indicated and/or make visits on alternative days (including the weekend) with the person's and/or the family's consent, if applicable, if there is an issue with driving after dark in remote areas.
The level of need is the overriding determinant of the type and frequency of contacts.

Since the Self-Determination waiver does not include residential services (Residential Habilitation, Medical Residential, Supported Living), the level of need of employment and day services will determine type and frequency of Case Manager contacts.
A person assessed to have level of need 1, 2, or 3 for purposes of reimbursement or not receiving any residential or day service requires:

- At least one in-person or telephone contact per calendar month
- in-person contact occurring at least every other month.
- for level of need 1, 2, or 3 **day or employment services** or services not based on level of need, a visit should be coordinated with the person or the person's family to occur every third month in the person's home **or in alternate locations as chosen by the person or the person's family**.
- Based on the person's or family's preference as applicable, **the home visit may be conducted through videoconference no more frequently than once every six months.**
- Generally, face-to-face visits should be coordinated with the person supported (and their family, as applicable) to occur in the person's residence. However**, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home.**

A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires:

- at least one face-to-face contact per calendar month across all environments.
- Based on the person's preference, the required monthly contact may be conducted with the person **through videoconference no more frequently than every other month.**
- If **only receiving a day or employment service** at level of need 4, 5, or 6, a visit should be coordinated with the person or the person's family to occur either in the person's home **or in alternate locations as chosen by the person or the person's family**.
- Generally, face-to-face visits should be coordinated with the person supported (and their family, as applicable) to occur in the person's residence. **However, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home.**

Advocacy Organization	Pages 18, 80 - 135

Included in the Proposed Renewal and Amendments to Tennessee's Section 1915(c) Home and Community-Based Services Waivers, Appendix D; revised language states : "Upon the integration of these services into managed care and as part of educational materials developed by TennCare and discussed with each waiver participant by his/her ISC as part of the annual person-centered planning process and included in the Member Handbook, each waiver participant will be reminded of his/her

right to direct and be actively engaged in the person-centered planning process to the extent desired, and his or her authority to decide who is included in the process."

Nowhere does it state that the individual will be provided sufficient information as to all state programs, so as to make a fully informed choice. Specifically, the option for Intermediate Care Facility (ICF) services is missing from the entire document, other than to reference it as 'not a preferred option' or to incorrectly characterize ICF as a behavioral alternative to Waiver.

Unfortunately, the tools necessary to provide the sorts of "behavioral" (code for severe mental health) services contemplated in the original, "Concept Paper and Joint Plan to Transform Tennessee's Service Delivery System for Individuals with Intellectual and Developmental Disabilities"; and carried forth in these proposed Waiver Amendments, do not adequately address the service needs of the individuals contemplated therein. They deserve to receive services whether temporary, intermittent, or permanent but to date there are insufficient facilities for such measures. Intermediate Care Facilities are not the appropriate source for treating severe mental illness.

The community settings that ICF homes, built as part of the transition from state run institutional facilities, are located in true residential areas and many of the clients/patients would pose a threat to community members and other clients and staff. Further, under CMS regulations (and DIDD Survey requirements) related to the operation of Intermediate Care Facilities, restraints such as those required to properly manage such inpatients (including PRN medical restraints, locked units and well as physical (tie down) restraints contemplated therein are not permitted) and pose a violation of Client Protection from Harm, as currently interpreted by DIDD.

As an alternative, the state could develop a short stay Mental Health Facility for such individuals, which would be located in a commercial setting and would permit the appropriate protections from harm to the individual and the community. Being that it would be larger than the current four bed facility, it would be more cost effective and a model for others to follow.

If saving money is the immediate goal, in order to relieve the wait list, the state could discontinue the practice of paying Medical-Residential providers at the 50th percentile of ICF, a false equivalency, thus making Med-Res the most costly residential program. Let me explain. ICF provides a greater level of benefits (i.e., Nursing, Medical Director, staffing, Dental, certain medications, special purpose homes, DME, etc.) and they pay a 5% bed tax on all revenues, which the Med-Res providers do not pay but get to participate financially. The savings from the bed tax alone would pay for a thousand wait list slots.

Thank you for the opportunity to share my thoughts.

Thank you for your comments and suggestions.

Appendix B-7 of the current 1915(c) waivers details the Freedom of Choice process by which individuals must be "informed of any feasible alternatives under the waiver" and "given the choice of either institutional or Home and Community Based Services" (HCBS). This process includes all programs and services for which the person is eligible. The 2023 renewal/amendments propose an additional Community-Informed Choice (CIC) process, which will be completed by the MCO, in conjunction with DIDD, and will ensure that waiver participants who are considering or seeking transfer from the waiver to an ICF/IID are timely engaged to ensure their choice of services and settings is made through a community informed choice process that identifies alternatives through

which the individual could continue to be supported through HCBS programs, receive services in the most integrated setting where the person's needs can be effectively met, and avoid unnecessary institutionalization prior to the transition being approved.

HCBS is considered the preferred option for people receiving Long Term Services and Supports, including those with significant behavioral health support needs. The Freedom of Choice and proposed CIC processes are intended to be an individualized approach to ensuring that people have the information necessary to make an informed decision on which supports and setting best meet their needs and preferences.

The waivers offer a short-term Behavior Respite service, not to exceed 60 days per calendar year, which offers individual specific supports to individuals experiencing a behavior crisis that requires removal from the current residential setting in order to assist in resolving the crisis. These supports include behavioral intervention for aggressive or inappropriate behavior that jeopardizes the health and safety of the person supported or others. In addition, statewide initiatives and partnerships are ongoing related to increasing the capacity of behavioral health services in Tennessee.

Service Provider (other than DSP)	Pages 116-120

We are asking once again that ICF services not be a part of the state-wide integration plans. ICF services should not be funded by MCOs. They should remain responsive to the immediate needs of our most vulnerable citizens, not rely on cumbersome MCO billing practices. They should also continue under the Department of Health regulations instead of DIDD/MCOs. It is never a good idea to have one state agency responsible for all services delivered to a population of people. Accountability is lost in monopolies. Choice is lost.

Thank you for your comment.

Under the state's proposal, ICF/IID services will continue to be available to qualifying members as medically necessary pursuant to the current level of care criteria; these services will be part of the state's managed care program in the same manner as HCBS for members with intellectual disabilities. In addition to the ongoing statewide initiatives and partnerships related to increasing the capacity of behavioral health services, much thought and consideration has been placed into planning for the implications of bringing ICF/IID services under managed care.

With the proposed renewal/amendments and I/DD Integration, providers will continue to submit their billing through the DIDD billing portal. DIDD will then send claims electronically to TennCare, and TennCare will then separate the claims and send to the appropriate MCO. The MCO will then process the claims and pay the providers at the rates established by the State and provide a remittance advice to each provider. Further details regarding the proposed process for MCO provider payments are included in the proposed waiver renewal/amendments.

The DIDD ICF/IID survey team will retain responsibility for the initial and annual Medicaid re-certification of all privately operated ICFs/IID. The Tennessee Department of Health/Health Care Facilities will retain the ICF/IID survey responsibilities for the DIDD state operated ICF/IID providers.

Family Member/Representative of a person supported	Page 2

Referring to Integration of the HCBS provided under these waivers into managed care, utilizing concurrent 1115 authority as part of an amendment to the TennCare III demonstration, including Managed Care Organization (MCO) responsibilities under the waiver.

I have deep concerns about adding the layer of bureaucracy of the MCOs between the person served and DIDD. Families and individuals currently served in ECF Choices often have great difficulty in getting an answer to their questions, in part because of the inexperience of the MCOs' support coordinators and the inexperience of the MCOs themselves in providing LTSS. As the parent of a young adult in the Statewide Waiver, we've rarely had those issues. DIDD knows LTSS, the MCOs do not.

And I'm not sure if this is in Appendix A, but I very much value the INDEPENDENT support coordinator that my son has, and I dread having to deal with someone in a call center from one of the MCOs who may or may not have any real experience providing LTSS. There is also a great deal of turnover in the MCOs' support coordinators, whereas the INDEPENDENT support coordinators are often longtime employees of local agencies, knowledgeable of the local resources.

Clarifying in Appendix B-6 that in order to remain eligible for the waiver, a person must not only need, but actually receive ongoing waiver services. o “In order to be eligible for this waiver, the person must require a program of specialized services and but for the provision of those services, require the level of care provided in an ICF/IID. Accordingly, a person must receive at least one ongoing waiver service in addition to independent support coordination on an ongoing basis—at a minimum, quarterly.”

This language could easily penalize individuals who need services, but cannot receive them because there are no provider agencies willing to serve the individual, either because of the person's behavior issues, where the person lives or because the agency simply has no staff

My son was enrolled in the Statewide Waiver in 2015, but it wasn't until late 2017 until we were able to find an agency to serve someone with my son's intense behavior issues and also willing to serve him in the county we live in. If this rule had been in place, even though my son desperately needed supported living, he could have been disenrolled because for those two years all he was receiving was support coordination.

And I know many families personally whose loved ones are doing without the needed supports and services because agencies simply do not have the staff to provide personal assistance, respite care, employment supports, community participation and more.

This seems hugely unfair!

Thank you for your comments.

Our plan for transitioning the 1915(c) waivers into managed care is focused on maintaining and elevating person-centered values within the person-centered planning process. **With this renewal and amendments, waiver members will not lose their ISCs/CMs.** Waiver participants’ ISCs and CMs will continue to facilitate the person-centered planning process and evaluation of 1915(c) waiver supports and will maintain their relationships with waiver participants and their support networks.

The waivers have indicated for some time that in order to remain eligible for the waiver, the person must need at least one service in addition to Support Coordination/Case Management on an ongoing

basis, at a minimum, quarterly. The state is proposing this change to further clarify this federal requirement that members enrolled continue to need ICF/IID level of care and would, but for the provision of the waiver services, otherwise be institutionalized in an ICF/IID. We are aware that some waiver participants experience lapses in service due to various reasons outside of one's control, including staffing shortages, lack of willing/able providers, and more recently, the COVID-19 pandemic. **Members will not be involuntarily disenrolled from the waiver under these circumstances.** However, there are also instances of waiver recipients not receiving services due to refusal of services or refusal to comply with waiver service requirements. TennCare and DIDD currently review and will continue to review and investigate all applicable lapses in waiver services on an individual basis before moving forward with actions to involuntarily disenroll someone from a waiver. All notices of involuntary disenrollment will be accompanied by appeal rights. [42 CFR 435.217, 42 CFR 441.302]

Family Member/Representative of a person supported	None Provided

Comments with respect to Tennessee's request for amendments to Tennessee's 1915c waiver services for persons with intellectual disabilities August 28, 2022

Introduction

These comments are submitted by the parents of, and conservators for, an adult child in the CAC waiver program. Our son has an intellectual disability, autism, a depressive disorder, catatonia, and incontinence. His condition required over four years of institutional placements, including stays of over eight months at the Middle Tennessee Mental Health Center and almost three years at the Neurobehavioral Unit of the Kennedy Krieger Institute in Baltimore Maryland, which serves children with a developmental disability who have life threatening behaviors. Thanks to the CAC waiver program, our son was able to return to Tennessee in 2010 to live in his own home with direct care staff helping him with all activities of daily living as well as his very complex medical needs, including very frequent out-patient medical treatments.

Our comments are informed by our experiences of almost 33 years as parents as well as his mother's experience for five years as a coordinator of mental health services for the Tennessee Department of Education and his father's experience of forty-six years as an attorney for the Legal Aid Society of Middle Tennessee and the Tennessee Justice Center where he represented low-income Tennesseans in civil matters including access to TennCare home and community-based services.

Our greatest concern is that over time, the amendment's proposal to "integrate" or "align" services will result in the reduction of the direct service care our son currently receives. He lives in his own home in the community with 24 hour services, at the level he needs. We have spoken with both families and providers who have informed us that it is not possible to provide 24 hour direct care services in the 1115 Employment and Community First CHOICES (ECF) waiver program due to the very low funding levels. TennCare has said that no waiver services will be changed when their proposal begins, but we are very concerned that there will later be cuts in waiver services so that 24 x 7 care will no longer be possible. We are also concerned that MCOs will be paid by TennCare in a way that creates a financial incentive to reduce services.

Our concern is informed by the action of TennCare in 2016 of closing the three 1915c waiver programs, including the CAC program, to new applicants. These programs are administered by the

Tennessee Department of Intellectual and Developmental Disabilities and funding is available to provide 24 hour direct service care for those persons for whom such care is medically necessary. In the place of the three 1915c programs, TennCare established in 2016 a managed care 1115 waiver program titled Employment and Community First CHOICES (ECF). The focus of the ECF program is moving persons with intellectual and developmental disabilities into competitive work. While nothing would make us happier than if our son could perform competitive work, given his abilities, this is extremely unlikely. We are aware of persons in the 1915c waivers who cannot see, speak, or move on their own and who require a ventilator to breathe. The ECF program does not provide sufficient funding for twenty-four hour direct service care for those who need it. We are aware of persons who have been turned away from the ECF program because their needs were too great and others who have been unable to obtain needed direct service care because the funding in the ECF program is insufficient. The goal of TennCare' s proposed 1915c amendments is to "align" the services available in the 1915c programs with those available in the ECF program.

TennCare has promised that no 1915c services will be cut immediately upon implementation of the proposed amendments, but no promises have been made with respect to service cuts after the implementation date.

The amendments propose to switch service determinations from the staff of DIDD, many of whom have extensive prior experience as providers of services for this population as well as many years of experience working with persons with intellectual disabilities, to managed care organizations who will eventually be paid through at-risk capitated payments.

Payments by MCOs to service providers will be changed from payments based on services provided to "value based reimbursement" which will provide incentive payments for placing people in competitive work and the use of technology to provide services. No details with respect to how these payments will be calculated have been provided nor has any information been provided with respect to how persons who are unable to perform competitive work or replace direct service care with technology will be protected if payments are based on things they cannot do.

The amendments provide for the potential elimination of the Independent Service Coordinators (ISC) who are not employed by the state and who act as independent service monitors and support for the families. The amendments also provide for new restrictions on nursing services.

Our comments with respect to the proposed amendments are provided below.

The proposed amendments state at page 2 that additional context for the changes, including how the changes will be operationalized, are contained in the Overview of Proposed Amendments and Changes to Integrate and Transform Long-Term Services and Supports (LTSS) for People with Intellectual and Developmental Disabilities (IDD) and A Concept Paper and Joint Plan to Transform Tennessee's Service Delivery System for Intellectual and Developmental Disabilities that are attached to the proposed amendments. These documents will be cited as Overview and Concept Paper in our comments.

1. Potential reduction in direct care services

There are currently two sets of programs which provide services for persons with intellectual disabilities. The three 1915c programs, which were closed to new applicants in 2016 and the 1115

Employment and Community First CHOICES program which was begun in 2016. The Overview states on page 4 that the plan for these amendments is to "create a single, seamless person-centered system of service delivery for people with I/DD". However, the Overview acknowledges on page 10 that the 1915c waiver programs and the 1115 Employment and Community First (ECF) program that it would be aligned with are "quite different". Funding for direct care services is much lower in the ECF program, which has as its focus moving persons into competitive employment. The Overview states on page 10 that all of the 1915c current programs will continue on July 1, 2021, but it does not state whether subsequent cuts are planned. Many individuals in the 1915c programs need direct care services for 24 hours. The ECF program does not provide sufficient payments to providers to make this possible. Individuals in the 1915c programs and their families are concerned that these amendments will result in a reduction in medically necessary direct care services. The Proposed Amendments should explicitly state that persons currently receiving services through the 1915 c waiver will not lose any services due to the Amendments and there will be no reduction in services unless they are no longer medically necessary.

2. Inadequate Provider Payments for Direct Care Staff

Many individuals who have been approved for direct care services are not getting them because payments to providers are too low. Many direct care staff are paid less than at other job opportunities like at Wal-Mart. The amendments state on page 14 that there is no formal process in place to review provider costs. A formal process should be established to review provider costs on an annual basis

3. Changes in Provider payments may adversely Affect Those with the Greatest Disabilities

The Overview says pages 21-22 that instead of payments to providers based on staff-ratios and the number of people living in a home, providers will be paid based on a system of "value based reimbursement". Page 22 of the Overview says the "measurement domains" for value based reimbursement "will be aligned with the Pillars of Transformation". The three "Pillars of Transformation which are on page 18 of the Overview are "Employment First", "Technology First" and "Person Centered Thinking Planning and Practices". Providers may not be able to provide needed direct care services for those with the greatest needs who are unable to perform competitive work and who need direct care services instead of technology such as video monitoring. The amendments should state what protections will be in place to ensure that providers serving persons who are unable to perform competitive work and who need direct care services instead of technology receive sufficient funding.

4. Replacement of Direct Care Staff with Technology

The proposed amendment states on page 3 that providers shall be responsible to explore enabling technology and implementation as appropriate. There is a concern that direct care staff will be replaced with technology-based monitoring such as video cameras for persons who need direct care staff for assistance with activities of daily living or to manage behaviors or medical need. The amendments should state that the person affected, and any legal representative have to consent to the replacement of direct service care with technology.

5. MCO capitated payments

Tennessee's proposed amendment states on page 18 that MCOs will eventually be paid a capitated rate for each waiver participant they serve. There is a concern that this will drive MCOs to reduce services for the persons requiring the highest level of care. The amendments should state what safeguards there will be to ensure that MCOs do not reduce or eliminate services in order to decrease expenses that must be paid out of the capitated rate received.

6. Services based on SIS scale

The Overview states on pages 16-17 that a determination of services will not be based on the staff needed or the number of persons receiving services in a home but instead based on a Supports Intensity Scale (SIS) questionnaire. A White Paper issued by the American Association on Intellectual and Developmental Disabilities states there needs to be an opportunity for an exception to the score. https://www.aaidd.org/docs/default-source/sis-docs/supportneeds.pdf?sfvrsn=a88b3021_0%20 on page 13. The amendments should state that there will be a process to make exceptions to the SIS.

7. Review of MCO decisions

The Overview states on page 17 that TennCare will allow review by DIDD of an MCO decision under unspecified circumstances. Because DIDD staff often are much more aware of the needs of a person for whom they have determined the services needed for many years than an MCO case manager, it is important for individuals and families to be able to seek a review of MCO service determinations. The amendments should provide that an individual on the waiver, a family member or a conservator or advocate be able to request a review of an MCO decision. Any decision by an MCO to deny or reduce 24 hour per day services should be reviewed by DIDD.

8. Restriction on Continuous Nursing Services

The amendments provide in Appendix C that nursing services are not authorized for a continuous period if skilled nursing services are not needed continuously which is defined as at least hourly during such period. There are persons within the 1915c waiver programs who require continuous care to ensure there is a prompt response in an emergency such as the failure of a ventilator. The amendments should recognize that such persons require continuous care.

9. Restriction of Nursing Services to Twelve Hours Per Day

The amendments in Appendix C unnumbered page 12 state that nursing services are limited to 12 hours per day. There are persons on the 1915c waiver programs who cannot speak, see, or move on their own and who are dependent on a ventilator to breathe. The amendments should allow for more than 12 hours per day of nursing care when it is medically necessary.

10. Limit on Therapy Services

Tennessee's proposed amendments state on page 3 that therapists shall "train staff to develop a plan for fading direct services to the extent possible and appropriate." There is a concern that while staff should certainly be trained by therapists to provide support for the people they serve, they are not qualified to replace professional therapists. It is also necessary for therapists such as behavior analysts to observe whether staff are following the behavior plan. The amendments should recognize that direct care staff cannot replace licensed therapists when their professional services are needed.

11. Restrictions on Access to ICF-IID facilities

Page 25 deletes existing waiver language with respect to the right to choose services from the waiver or from an ICF-IID. This language should not be deleted.

12. Potential Elimination of Independent Support Coordinators

The Overview states on page 16 that the efficacy of the Independent Support Coordinators (ISC) who coordinate services for persons on the waiver will be measured by how successful they are helping persons make life centered choices, utilizing enabling technology and achieving employment and community living goals. ISCs were established as part of the settlement of litigation brought by the United States Department of Justice with respect to the care provided for persons with intellectual disabilities in Tennessee. They are employed by not for profits such as the ARC to provide independent coordination of services and support for persons with intellectual disabilities. Individuals with intellectual disabilities and their families are very concerned about their potential elimination. The amendments should state that persons in the waiver will continue to have access to ISC services throughout the duration of the waiver.

13. MCOs can reject qualified providers

The amendments state on page 11 that beginning July 1, 2022, or a later date determined by TennCare, MCOs will no longer be obligated to contract with all providers deemed as credentialed by DIDD. Many persons on the 1915c waivers have had the same providers for many years. They have strong relationships with their direct care staff. The loss of those staff can cause significant emotional distress and regression. The amendments should retain the current waiver language that a person can use any willing provider approved by DIDD.

14. Must Be Receiving Services to Be Eligible

The amendments state on pages 24-25 that in order to be eligible for waiver services a person must not only need, but actually be receiving waiver services. The amendments should make clear that this will not be used to disqualify persons who have been approved for services but have been unable to locate a willing provider or who have a provider that is not actually providing the services.

15. Must have unpaid persons available as backup

The amendments on pages 24-25 provide that each Person Centered Support Plan (PCSP) will include unpaid persons who have agreed to serve as backup when scheduled workers and/or contract providers do not arrive or are unavailable. Some persons on the waiver do not have willing unpaid persons who will be able to serve when scheduled workers and/or contract providers do not arrive or are unavailable. The amendments should state that the PCSP should state whether there is an unpaid willing backup person.

16. DIDD should continue to make level of care decisions

Page 5 of the amendments deletes language that DIDD has responsibility for level of care determinations. This language should not be deleted since DIDD will continue to make these decisions for an unknown length of time.

17. Provider rates must be consistent with approved rate methodology

Page 17 of the amendments deletes this requirement.

18. ISCs should continue to assist persons in obtaining and coordinating services.

Page 21 of the amendments deletes the provision of this assistance.

19. Persons should have a right to a hearing with respect to a choice with respect to available qualified providers.

Page 29 of the amendments denies this right.

Thank you for your comments, questions, and longstanding commitment to people supported. Although much of the language outlined in the *Overview of Proposed Amendments and Changes to Integrate and Transform Long-Term Services and Supports (LTSS) for People with Intellectual and Developmental Disabilities (IDD)* and *A Concept Paper and Joint Plan to Transform Tennessee's Service Delivery System for Intellectual and Developmental Disabilities* attachments is relevant to the changes proposed in the upcoming waiver renewal/amendments, pages 1-79 of the document posted for public comment on July 29, 2022 titled *Proposed Renewal and Amendments to Tennessee's Section 1915(c) Home and Community-Based Services Waivers: Opportunity for Public Comment* detail the currently proposed changes included in the waiver renewal/amendments. As has been indicated since the inception of the concepts of Program Integration, beginning in early 2020, the process of aligning I/DD programs and services across all environments will be an evolutionary process and completed in stages, each of which will continue to include deliberation and collaborative effort with our stakeholder community.

1. The intent of the proposed changes is not to reduce needed services. In fact, the proposed changes are providing additional support options for the diverse population we serve. We have been and will continue working to ensure that persons supported and their families are fully informed and provided with helpful resources as we navigate integration. The I/DD Integration plan indicates that TennCare will maintain the existing 1915(c) waivers, while bringing them under managed care concurrently with the 1115 Demonstration. This does not mean that 1915(c) waiver services will merge with services in other LTSS programs; these services will remain distinctly under the 1915(c) waivers, and once approved, the amended waivers will be posted on TennCare and DIDD's website for public view, which will include the list of services and definitions under each 1915(c) waiver program. The majority of the services provided through the 1915(c) waivers are not primarily medical in nature **and to the extent medical services are necessary, those will remain available to people**. MCO denials, partial denials, or reductions in services will be appealable through the same system of appeals DIDD currently utilizes.

The successes we have experienced with new programming options, opportunities to introduce tools and training that provide for greater opportunities for a self-directed and independent life, whether those supports occur within the 1915(c) Waiver Programs or the ECF CHOICES program, have formed the basis for many of the proposed changes. We have engaged stakeholders in a variety of ways since

announcing the I/DD Integration plan in July of 2020 and will continue to do so. We believe that the successes achieved outweigh the challenges we have experienced, especially in regard to service delivery outcomes and efficiencies, as documented in the 1115 Evaluation and evidenced in the successes of nearly 5% of the 1915(c) population now living more independently by virtue of technology-enhanced service settings. It is our belief that bringing the 1915(c) waivers into alignment with other LTSS programs, will facilitate the initial phase of our over-arching goal of the I/DD Integration plan: to create a single, seamless, person-centered system of service delivery for people with I/DD.

2. TennCare and DIDD continually seek to ensure that providers are paid appropriate rates for their important work. The current rates are created using the methodology outlined in Tenn. Comp. R. & Regs 0465-01 et seq., which were promulgated through the Uniform Administrative Procedures Act Rulemaking provisions. Maximum allowable rates are established for each service based on an analysis of provider costs to deliver services and based on experience, as set forth in DIDD Administrative Rule. DIDD continues to adjust the rates, particularly the Direct Support Professional (DSP) hourly wage component within the rates, based on feedback from providers and current employment trends. The state has appropriated additional state funds since state fiscal year 2014 for provider rate increases across all waiver programs. DIDD regularly meets with providers at Statewide Planning and Policy Council meetings as well as other providers meetings and rates are discussed. Additionally, DIDD routinely reviews cost data for providers who are struggling financially and have requested technical financial assistance. There are opportunities through the Tennessee Department of Labor (DOL) Apprenticeship Program and competency-based training that offers structured, supervised, on-the-job learning to develop new skills which lead to a higher wage. The training programs offer a nationally recognized credential and wage increases. The ongoing work to further normalize proven effective skills and tools of independence and establish Value-Based Purchasing (VBP) incentives is also expected to offer provider agencies and the state future opportunities for investment into DSP wages. We expect that the proposed changes and workforce development efforts, combined with new initiatives to address staff shortages will result in successful outcomes.

3. Thank you for your feedback on our VBP initiatives. The Flexible Supported Living Rate proposed with the renewal/amendments is an initial introduction of VBP to the 1915(c) waivers and additional VBP approaches will be incrementally developed and implemented over time with ongoing stakeholder input. Work is still ongoing to develop subsequent portions of a VBP methodology for future implementation. As we have throughout, stakeholder feedback will be solicited and considered in all development efforts.

4. Enabling Technology is not a mandated service. It is focused on identifying opportunities where technology can empower each person to have greater control and independence in their own life to the extent they choose it. The use of Enabling Technology, like all services, is available to individuals who choose to explore the skills and tools available and includes the development of an Enabling Technology plan that contemplates uses and targets the intended increases in their independence. The intent of Enabling Technology service is not to replace staff support where needed but to support the independence, integration, and competitive, integrated employment of individuals with I/DD to the maximum extent possible, based on individual needs, goals, and preferences.

5. As with all TennCare populations and as required under federal regulations, when MCOs are “at risk,” MCOs must be paid an actuarially sound capitation rate based on the populations served and the services required under the contract. The MCOs are then required to provide all medically

necessary services in accordance with the member's plan of care, including services for those with the highest levels of need. As it relates to services for individuals with intellectual disabilities, the state does not intend to utilize a capitation (or risk)-based payment at this juncture. Using flexibility provided under federal regulations, MCOs will be reimbursed for the services they provide similar to the ECF CHOICES program. The state will continue to evaluate the payment approach going forward and should a risk-based payment approach be adopted in the future, will establish actuarially sound rates, with sufficient checks and balances to ensure that individuals continue to receive the services they need to live successfully in the community and achieve their individualized goals.

6. The proposed amendments do not include changes to the Supports Intensity Scale (SIS), but we will take your comments into consideration. MCO denials, partial denials, or reductions in services will be appealable through the same system of appeals DIDD currently utilizes. That is, all service-related appeals will continue to go through the TennCare Solutions Unit and to the Medical Services Appeals Division, set for administrative hearing before Tennessee Secretary of State Administrative Law Judges as contested case hearings under the Tennessee Uniform Procedures Act.

7. TennCare, DIDD, and the MCOs have established and are continuing to strengthen our partnership in planning for I/DD Integration and the proposed waiver changes. Again, the intent of the proposed changes is not to reduce needed services and there will be no changes to the amount of services members receive. With the renewal/amendments, the MCOs will only be assuming responsibility for provider claims payments and management of the provider network. At some point in the future, Person-Centered Support Plan (PCSP) authorization will transition to the MCOs with careful and close coordination with both DIDD and TennCare to ensure medical necessity criteria is correctly and consistently applied. MCO denials, partial denials, or reductions in services will be appealable through the same system of appeals DIDD currently utilizes.

8. The person's physician, physician's assistant, or nurse practitioner will determine the person's need for continuous Nursing services, including the nature and frequency of skilled nursing tasks. As with all waiver services, supports will be provided to ensure the health and safety of the person supported, based on his or her unique needs.

9. In addition to Nursing services, the Comprehensive Aggregate Cap and Statewide waivers offer Medical Residential services, which includes the provision of direct skilled nursing services up to 24 hours per day/7 days per week and habilitative services and supports that enable a person supported to reside in a community-based setting. Individuals enrolled in the waiver program may also be eligible for nursing services through their MCO.

10. The proposal to implement a consultative model for therapies is not intended to replace qualified therapists and their expertise. As indicated in the public posting document, the proposed consultative model for therapy services leverages licensed therapy professionals to teach, train, and support paid and unpaid caregivers, embedding appropriate treatment within the day-to-day delivery of supports in order to maximize both the efficacy and efficiency of service delivery, and for developing a plan for fading direct services to the extent possible and appropriate. The provider network will be provided with additional guidance, training, and support to facilitate successful implementation of this consultative model. We will continue our engagement of stakeholders and monitoring for improvement opportunities throughout implementation of these changes and beyond.

11. We removed this language because it is duplicative of language included throughout the Service Plan Development section, which indicates that the person-centered planning process, including PCSP development, is directed by the person, involves coordination with the MCO regarding the person's physical and behavioral health care needs and goals, and the person's needs, preferences, and goals are identified and included in the person's PCSP as part of this process.

12. Independent Support Coordinators (ISCs) remain a part of both the CAC and Statewide Waivers as outlined in the proposed amendments. Any change to this or any other waiver service must be approved by CMS through a waiver amendment and after a public notice and comment period. Waiver members will not have both a MCO case manager and ISC or DIDD CM. **They will retain their current ISC or DIDD CM.**

13. As of July 1, 2022, new 1915(c), Katie Beckett Part B, and ECF CHOICES providers are credentialed by DIDD using standards consistent with waiver provider qualifications, contract requirements, and National Committee for Quality Assurance (NCQA) standards. These standards were also established in partnership with DIDD and MCOs, with input from I/DD stakeholders. Providers will be periodically re-credentialed by DIDD using these collaborative standards. Both DIDD and the MCOs will have responsibility to ensure adequacy of the provider network. MCOs will be obligated to contract with all 1915(c) providers "deemed" by DIDD to continue the seamless delivery of current services as specified in each person's approved Individual Support Plan, without gaps in care for at least the first six (6) months following implementation of the integrated I/DD system, or the remainder of their ISP year, whichever is later. This requirement will minimize potential disruptions in care, allow time for effective person-centered planning, and facilitate transition to another provider selected by the person if the current provider will no longer be part of the MCO's network once the continuity of care period has expired. In rare instances where concern may be noted related to network capacity for specifically identified and specialized services, DIDD has the authority to assure contractual linkages between an identified provider and the Managed Care Networks.

14. The waivers have indicated for some time that in order to remain eligible for the waiver, the person must need at least one service in addition to Support Coordination/Case Management on an ongoing basis, at a minimum, quarterly. The state is proposing this change to further clarify this federal requirement that members enrolled continue to need ICF/IID level of care and would, but for the provision of the waiver services, otherwise be institutionalized in an ICF/IID. We are aware that some waiver participants experience lapses in service due to various reasons outside of one's control, including staffing shortages, lack of willing/able providers, and more recently, the COVID-19 pandemic. **Members will not be involuntarily disenrolled from the waiver under these circumstances.** However, there are also instances of waiver recipients not receiving services due to refusal of services or refusal to comply with waiver service requirements. TennCare and DIDD currently review and will continue to review and investigate all applicable lapses in waiver services on an individual basis before moving forward with actions to involuntarily disenroll someone from a waiver. All notices of involuntary disenrollment will be accompanied by appeal rights.

15. The back-up plans for persons supported receiving services in their own homes will be developed, implemented, and amended as appropriate based on each individual's support network and available staffing.

16. TennCare will continue to make final approval decisions for all level of care evaluations and reevaluations. DIDD will continue to ensure that all members continue to meet ICF/IID level of care

criteria and may also be required to perform additional re-evaluations of the member's need for continued enrollment in the Waiver based on lapse in services or changes in the member's medical condition.

17. Page 17 of the public posting document does not reflect deletion of the requirement that provider rates must be consistent with the approved rate methodology. Under Appendix I Quality Improvement: Financial Accountability, sub-assurance b. requires that provider rates are consistent with the approved rate methodology, and we will continue to have a performance measure in place to measure compliance with this sub-assurance.

18. As stated above, we removed this language because it is duplicative of language included throughout the Service Plan Development section. Page 22 of the public posting document includes waiver language stating that "the ISC is responsible for coordinating waiver and other services and supports identified in the PCSP."

19. As part of the managed care program, individuals will continue to select their choice of provider from among those contracted with their MCO that is willing and available to initiate services timely and to consistently provide services in accordance with the PCSP. The person is not entitled to receive services from a particular provider or to a fair hearing if he is not able to receive services from the provider of his choice.

Service Provider (other than DSP)	Page 6

I do not see how allowing manage care organizations to administer the waiver services under the leadership of DIDD is cost effective and efficient. DIDD has many years of experience working directly with providers so it's puzzling as to why providers will be under the oversight of two (2) State agencies and three (3) MCOs. Adding additional entities to the service delivery system will create confusion in an already complicated system.

I believe it should be disclosed what the looming integration looks like in terms of total staffing and budgets/funding for TennCare, DIDD and all three (3) MCOs (not including direct funding to providers) and a comparison to what it looked like before the implementation of the ECF waiver. It appears, financially speaking, that the oversight mechanism of the ID system (TennCare, DIDD, and MCOs) are gaining weight while the providers are starving.

Thank you for your comment.

We acknowledge that the proposed changes are significant, but we also acknowledge that change is necessary for service delivery system improvement. The goal of integration is to leverage the unique expertise of each entity, not to duplicate or add layers of oversight. The success of our provider network is essential to achieving our vision for system transformation. The plan to integrate programs and services, including the alignment of reportable event management, quality assurance and improvement, direct support workforce training and qualifications, and provider qualifications and enrollment/credentialing processes, was designed to support providers by facilitating a seamless service delivery system and reducing administrative burden. We are committed to supporting providers before, during, and after these changes.

Service Provider (other than DSP)	Page 18

The language used in this section doesn't represent persons supported who don't have the cognitive and/or verbal abilities to comprehend and/communicate participant centered planning. Much of what is presented by the State in relation to service delivery is focused more on those persons supported who function on higher levels versus those with extreme limitations and who need hands on care.	
Thank you for your comment. While it's both understood and anticipated that people supported have a diverse level of ability and desire to participate in development of their person-centered plan, the expectations are that people receiving supports are involved, to the extent that they can and want to be, and any additional support and information is provided by those who are designated, by the person or the court, to best represent their desires.	
Service Provider (other than DSP)	None Provided
Appendix F discusses the Value Based Purchasing (VBP) initiative. My comment is based on not knowing full details of what this initiative will look in its implementation. Value based reimbursement is concerning as there is a fear that not meeting key outcomes will result in either not being reimbursed or receiving lowered reimbursement. This fear is speculative in nature. It should also be noted that not meeting an outcome doesn't necessarily mean the provider didn't do its job. There are many variables outside the providers reach that can stand in the way of outcome success.	
Thank you for your feedback on our VBP initiatives. The Flexible Supported Living Rate proposed with the renewal/amendments is an initial introduction of VBP to the 1915(c) waivers. While work is still ongoing, it is important to note that the currently developed domains and metrics that will lead to a more layered and extensive VBP methodology, have been developed in collaboration with a diverse group of providers, including support coordination input. As we begin to develop the next phase of introduction of VBP initiatives, we will continue to work directly with our network and broader stakeholder community.	
Family Member/Representative of a person supported	None Provided
My son is in the CAC Waiver (home based). He has been approved for 12 hours of nursing services 7 days a week. For several months he has only been receiving nursing services 1 day a week. This is because the reimbursement rate paid to the nursing agency under the current waiver is substantially below the market rate for nurses. The reimbursement rate under TennCare is much higher and more competitive. It appears that the nursing rates are remaining the same under the proposed Waiver Amendment. Rates will increase for the DSP, but not nursing. If the State is integrating the Waivers with TennCare then the nursing rates should be the same. My son has durable medical equipment which requires two individuals to safely put him in the equipment. In addition, in order for him to participate in community life, he needs two individuals to take him out into the community. There needs to be a provision that would allow a second DSP to assist with the equipment and for community participation if the approved nursing services are not being fulfilled.	

The ISC is charged with assuring that the services are person centered and assuring the health and safety of the individual. The durable equipment requires two individuals to get my son in the equipment and two individuals to take my son out for community participation. My son's approved services include a nurse and DSP, but if a nurse is not available, there needs to be a provision to allow for a second DSP.

Thank you for your comments.

We recognize the significance of the nationwide DSP and Nursing staffing crisis and the need to address this systemic issue within our service delivery system. Although Nursing rate increases across the board are not being proposed with the renewal/amendments, there was a recent rate increase implemented on 07/01/22 for Nursing services in the waivers. The proposed changes to the Nursing service as part of this renewal and amendments do also include a higher rate for Registered Nurse services for Self-Directed Health Care Tasks, which is intended to incentivize providers and staff for provision and support of these tasks. The Self-Direction of Healthcare Tasks gives members the option to direct and supervise a paid staff member in the performance of health care tasks that would otherwise be performed by a licensed nurse. We expect that these proposed changes to Nursing services in addition to workforce efforts and initiatives to address nursing staff shortages will result in positive outcomes.

Provider reimbursement for two Personal Assistants is not available under the waiver authority and is not being proposed as part of this renewal/amendment. It is recommended that the member and support network explore other support options and work with the ordering practitioner to train PA/DSP staff on equipment utilization in the community as authorized.

Advocacy Organization	None Provided

Appreciate Consumer Direction is included in all three 1915c waivers. Support coordinators should ensure that people supported and families know they can adjust their Consumer Directed budgets to fit their needs.
Appreciate the addition of Enabling Technology as a distinct benefit and that the limit of $10K can be used over two years.
We appreciate the emphasis on the importance of each person supported and their supporters, where appropriate, actively participating in defining their goals and preferences. All policies and rates should reflect the emphasis on person-centered support and ensure there are not barriers to individuals having options to be successful.
We do have some concerns that we would like to see addressed or answered Does introducing flexible rates in residential and day services indicate that base rates will be reduced? Many providers will be severely impacted if rates are reduced. To provide a staple network of providers, rates must be sufficient to meet person-centered plans, Given the removal of the minimum age requirement of 18 years old for direct support staff, are there any limits on who can be hired as a DSP?
With Value-Based Purchasing (VBP) Initiatives for flexible residential rates, will residential rates remain stable with no reductions?
Will VBP require certifications available only at a cost? Unless options are available at no cost, providers may be limited in what they can obtain even if they want to participate.

Thank you for the opportunity to provide feedback. Please let me know if you have any questions. I can be reached at hhaines@thearctn.org

Thank you for your feedback and your support of our system transformation values.

The renewal/amendments will not be reducing Supported Living rates with the introduction of the new VBP flex Supported Living rate. Rather, this additional option provides opportunities for people supported to gain, or regain, components of direct control and independence in their lives. This new approach will also allow providers to redistribute valuable direct care resources to those who truly need them while potentially reducing emotional strain on those DSPs and the financial stressors caused by lack of staffing and excessive overtime. Additional information is coming soon that will provide more details around the new rate. Work is still ongoing to develop a solid VBP methodology for future implementation and we will definitely consider your feedback.

We are proposing to remove the minimum DSP age requirement to support our workforce efforts and allow for more flexibility in hiring DSPs. Specifics will not be included in these renewal/amendments, but additional information will be coming soon through engagement with stakeholders to confirm these details prior to implementation.

Family Member/Representative of a person supported	# 1 & 2-pages 76, 78, 96; Comments # 3- pages 19 & 77

1. Need consideration to DIDD going to the TN State Board of Nursing to ask for a waiver for DSP to be able to hook up/administer oxygen, disconnect oxygen, and do O2 Stats. Since there is a shortage of nurses nationwide with problem exacerbated by Covid, need for DSP as primary caregiver to be able to do these skills since our son is going without most of his needed nursing services. (Much like DIDD received a waiver many years ago to begin med administration for DIDD clients). Also, can ask for a waiver for DSP to be able to administer other injectable, Subcutaneous Medications as DSP is allowed to give injectable Epinephrine. Our son is on an injectable osteoporosis daily medication which per current standards has to be administered by the nurse. This medication is preloaded, and DSP does not have to calculate dosage of medication.

2. DIDD nursing rates need to be increased to match the TennCare nursing rates. Right now, the DIDD nursing rate is about 1/2 of the TennCare nursing rate. This is what is contributing to the shortage of nurses working in the DIDD program as the DIDD nursing rates are not compatible with the TennCare nursing rates or the current marketplace. In fact, the DIDD nursing providers have not seen an increase in the DIDD nursing rates for the 30 years our son has been in the program. When a DIDD client in the CAC waiver needs the supports to live at home and be a part of the community, DIDD needs to adequately and safely support the DIDD client in the setting per Person Centered Care and Choice.

DSP- When ISP calls for 2 staff to get a client into equipment per therapy plans, and for 2 staff to take the client out safely into the community for Community Participation, when there is no nurse functioning as the 2nd staff person, DIDD needs to allow 2 DSPs to work concurrently during peak hours.

General comments- Questions asked last year of DIDD during first attempt at CMS submission. However, DIDD drafted the Concept Paper and did not know the answers clients and families asked, including our above comments/questions. Now almost one year later, DIDD does still not know the answers or have a plan to address the concerns of clients/families. How can changes/attempts be made to alter plan of care when DIDD does not know the specific answers on how the Program will work? DIDD seems very evasive.

Right now, some DIDD nursing services are provided 12 hours per day 7 days per week to some clients. MCO nursing services for adults are limited to 30 hours per week. Clients/families ask if nursing services will be cut once DIDD transitions nursing services to the MCO, and we cannot receive an answer in the name of transparency!

Also, since DIDD is not able to provide the nursing services for our son, the MCO was asked to assist. The nursing hours, instead of 84 hours weekly are limited to 30 hours of nursing weekly. Additionally, the MCO has been searching for nursing services for about 5 months and the MCO cannot provide nursing services. So, if DIDD is going to transition nursing services to the MCOs, how will the numerous clients be able to receive the MCO nursing services. This proposed DIDD plan to submit to CMS regarding the TennCare Concept Paper has not been well thought out and is not workable in its current proposal.

DIDD does not seem to care that our son does not have 2 staff to get him into and out of his durable medical equipment. Also, our son does not have the 2 required staff per his ISP to safely go out and participate in Community Participation. DIDD does not seem to care that our son has to remain at home instead of venturing out in the community and participating in the many community activities our son was participating in and is also not able to do his volunteer hours.

When DIDD ISP services are not being provided due to lack of staff i.e., nursing services- TennCare will not allow clients/families/advocates to appeal to the TennCare Solutions Unit (TCSU). TCSU states it is not appealable because the TCSU agrees DIDD should be providing the ISP approved services. However, because the ISP services are DIDD approved but not provided, this is not appealable. Therefore, clients are going without much needed services and supports to remain supported in their communities, with no solution.

Thank you for your comments.

1. Based upon the authority in Tenn. Code Ann. 68-1-904 and 71-5-1414, the proposed renewal/amendments introduce Self-Directed Healthcare Tasks for Nursing services, which gives members the option to direct and supervise a paid staff member in the performance of health care tasks that would otherwise be performed by a licensed nurse. The TennCare/DIDD Self-Directed HealthCare Tasks protocol is being finalized and stakeholders will be informed when this option is available.

2. We recognize the significance of the nationwide DSP and Nursing staffing crisis and the need to address this systemic issue within our service delivery system. Although Nursing rate increases across the board are not being proposed with the renewal/amendments, there was a recent rate increase implemented on 07/01/22 for Nursing services in the waivers. The proposed changes to the Nursing service as part of this renewal and amendments do also include a higher rate for Registered Nurse services for Self-Directed Health Care Tasks, which is intended to incentivize providers and staff for provision and support of these tasks. The Self-Direction of Healthcare Tasks gives members the option to direct and supervise a paid staff member in the performance of health care tasks that would otherwise be performed by a licensed nurse. We expect that these proposed changes to Nursing services in addition to workforce efforts and initiatives to address nursing staff shortages will result in successful outcomes.

Provider reimbursement for two Personal Assistants is not available under the waiver authority and is not being proposed as part of this renewal/amendment.

All stakeholder feedback from the I/DD Integration waiver amendments submitted last year have been recorded and many of the same questions and comments are included in this year's submissions. Per standard practice, DIDD engaged stakeholders, including the provider community and family members/support networks during the public comment periods in 2021 and 2022. DIDD, in collaboration with TennCare and the MCOs, will continue diligent efforts to address all stakeholder questions and concerns around I/DD Integration and related waiver renewals/amendments. Strategic work continues among TennCare, DIDD, MCO, and other stakeholders to identify, plan, and initiate actions needed to successfully implement the I/DD Integration plan and related changes. This work includes frequent and ongoing communications with providers and families, which will continue upon implementation and throughout the evaluation process.

The intent of the proposed changes is not to reduce needed services and there will be no changes to the amount of services members receive. With the renewal/amendments, the MCOs will only be assuming responsibility for provider claims payments and management of the provider network. At some point in the future, Person-Centered Support Plan (PCSP) authorization will transition to the MCOs with careful and close coordination with both DIDD and TennCare to ensure medical necessity criteria is correctly and consistently applied. MCO denials, partial denials, or reductions in services will be appealable through the same system of appeals DIDD currently utilizes. The I/DD Integration plan indicates that TennCare will maintain the existing 1915(c) waivers, while bringing them under managed care concurrently with the 1115 Demonstration. This does not mean that 1915(c) waiver services will merge with services in other LTSS programs; these services will remain distinctly under the 1915(c) waivers.

As stated above, provider reimbursement for two Personal Assistants is not available under the waiver authority and is not being proposed as part of this renewal/amendment. It is recommended that the member and support network explore other support options and work with the ordering practitioner to train PA/DSP staff on equipment utilization in the community as authorized.

Under Appendix F of the waiver renewal/amendments, the Medicaid Agency will provide an opportunity for a fair hearing to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the services and settings of their choice. This does not include services not provided due to missed shifts or lack of staff. Services not provided in the amount, frequency, duration, and type/scope as indicated in the ISP/PCSP are monitored and remediated through provider quality assurance surveys and reported to CMS annually.

Other -TN Alliance of Support Coordination (TASC)	Pages 4, 11, 21

(Page 11) TASC strongly recommends Independent Support Coordination remain under the direct supervision of DIDD in lieu of the MCO's to maintain independence from the competing objectives of the MCO's/provider network. Appendix C/Support Coordination Service definition: TASC is in agreement and appreciates the flexibilities and concise language around contact requirements. Thank you for collaborating with us to develop standards that work well for people using services and the fee-for-service model. We applaud the changes made, and the efforts to ensure quality support coordination while balancing COVID/health risks at the ground level. THANK YOU!

(Page 21 and 24) We applaud the decision to create a designated space in the PCSP to house/plan for risk management strategies. Our understanding is that the RIIT/RAPT forms (current uniform tools) will no longer be required documents for the providers/ISC's in the PCSP development process. Question: Does "the administration of a uniform risk assessment" require the completion of the RIIT/RAPT? Or does the authorized PCSP, with the risk management section completed, meet the requirement?

(Page 4) Appendix B-6 - " in order to be eligible for this waiver.... must receive at least one ongoing waiver service....at a minimum, quarterly"

TASC would like to request more information about how this new rule will be implemented. What are the protections/considerations when network capacity is the barrier? Will ongoing attempts to locate a provider/reestablish services be acceptable to prevent involuntary disenrollments for people seeking services? We currently serve many folks who are seeking providers/services, but many network barriers (COVID, staffing crisis, closed to new referrals) are causing a delay in re-establishing service plans.

Thank you for your recommendations and continued support.

The waivers have indicated for some time that in order to remain eligible for the waiver, the person must need at least one service in addition to Support Coordination/Case Management on an ongoing basis, at a minimum, quarterly. The state is proposing this change to further clarify this federal requirement that members enrolled continue to need ICF/IID level of care and would, but for the provision of the waiver services, otherwise be institutionalized in an ICF/IID. We are aware that many waiver participants experience lapses in service due to various reasons outside of one's control, including staffing shortages, lack of willing/able providers, and more recently, the COVID-19 pandemic. **Members will not be involuntarily disenrolled from the waiver under these circumstances.** However, there are also instances of waiver recipients not receiving services due to refusal of services or refusal to comply with waiver service requirements. TennCare and DIDD currently review and will continue to review and investigate all applicable lapses in waiver services on an individual basis before moving forward with actions to involuntarily disenroll someone from a waiver. All notices of involuntary disenrollment will be accompanied by appeal rights. [42 CFR 435.217, 42 CFR 441.302]

The authorized PCSP with the risk information included will meet the risk information requirement needed in the person's planning process.