Proposed Renewal and Amendments to Tennessee's Section 1915(c) Home and Community-Based Services Waivers: Opportunity for Public Comment

This document provides formal notice and opportunity for public input regarding proposed changes to each of Tennessee's Section 1915(c) home and community-based services (HCBS) waivers:

Waiver TN.0128.R06.00

Statewide Home and Community Based Services (or "SW") waiver

Waiver TN.0357.R04.00

Comprehensive Aggregate Cap Home and Community Based Services (or "CAC") Waiver

TN.0427.R03.02

Tennessee Self-Determination (or "SD") Waiver Program

The currently approved waiver applications are available here:
https://www.tn.gov/tenncare/policy-guidelines/tenncare-1915-c-hcbs-waivers.html

These waivers are operated by the Department of Intellectual and Developmental Disabilities (DIDD) under an Interagency Agreement with TennCare, the State Medicaid Agency.

The requested effective date of these changes is January 1, 2023.

The primary purpose of these waiver submissions is to submit the SD Waiver Application for a renewal period of five years and to **resubmit** the Intellectual and Developmental Disabilities (I/DD) Integration changes that were submitted to the Centers for Medicare and Medicaid Services (CMS) in September 2021 to transition 1915(c) HCBS provided under all three waivers into managed care, using concurrent 1115 waiver authority as part of an amendment to the TennCare III demonstration. The individuals served in these waivers are already part of managed care for their physical and behavioral health services. These changes simply integrate 1915(c) HCBS waiver benefits for individuals with I/DD, with their current managed care health plan also becoming responsible for the delivery of 1915(c) HCBS waiver services.

I/DD Integration will allow Tennessee's State Medicaid Agency and State I/DD Agency to achieve a number of shared goals:

- Create a single person-centered system of service delivery for individuals with I/DD.
- Utilize the Department's extensive expertise and agency purpose across all programs serving individuals with I/DD.
- Build upon TennCare's health plan partnerships and the successes we've experienced in CHOICES and Employment and Community First CHOICES—both in outcomes and efficiencies, as documented in our 1115 Evaluation.
- Improve coordination of physical and behavioral health and home and community-based services.
- Set the stage for value-based reimbursement aligned with key outcomes and with the federal HCBS Settings Rule:
    - Independence
    - Community participation
    - Competitive Integrated Employment

  (Reimbursement changes will be part of subsequent amendments to these waivers and are not part of this request.)

- Align programs, processes, and requirements to achieve administrative efficiencies for health plans and providers.
- Maximize increased revenue opportunity via the State's HMO premium tax, which will help to prevent cuts that would otherwise likely be necessary to benefits and/or reimbursement.
- Leverage increased efficiencies in the delivery of services to address the waiting list for individuals with I/DD (subject to the State's budget process).

Additional context for these changes, including information about how the changes will be operationalized, is provided in *A Concept Paper and Joint Plan to Transform Tennessee's Service Delivery System for Individuals with Intellectual and Developmental Disabilities*, released in early July 2020, and a more comprehensive *Overview of Proposed Amendments and Changes to Integrate and Transform Long-Term Services and Supports (LTSS) for People with Intellectual and Developmental Disabilities (I/DD),* released in September 2020 (both attached hereto).

Additional information (including presentations regarding these changes, FAQs, etc.) is available on the TennCare and DIDD websites:
https://www.tn.gov/tenncare/long-term-services-supports/idd-program-integration.html
https://www.tn.gov/didd/for-consumers/didd-waiver-information/idd-program-integration.html

The I/DD integration amendments were previously posted for public comment on February 19, 2021. If you previously submitted comments related to these changes in 2021, it is not necessary to resubmit those comments again.

Except as otherwise noted, the proposed changes are applicable across each of the three 1915(c) waivers.

The summary of proposed **changes which were previously included in the prior public notice** includes:

- 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 (see Section I below).
- 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.
    - "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."
- The introduction of a new Community Informed Choice process for waiver participants considering or seeking transfer from the waiver to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) in order to ensure an informed choice of services and settings through a process which identifies alternatives through which the individual could continue to be supported in the community, avoid unnecessary institutionalization, and receive services in the most integrated setting appropriate and clarifications regarding freedom of choice as it relates to choice of providers under managed care (Appendix B-7; freedom of choice of providers is detailed in Appendix D-1(f) below)
- Person-centered updates in Support Coordination processes and expectations, including an Employment Informed Choice process (see Section II below).
- Adding consumer direction options for Statewide and CAC Waivers (see Section III below).
- Adjustments to Appendix C Waiver Services, as follows—see Attached Appendix C for additional detail, as applicable.
    - Revisions to the definition of Support Coordination services to reflect person-centered expectations aligned with program goals (detail attached)
    - Adding Enabling Technology as a distinct benefit and consistent with the currently approved Appendix K to each of the Section 1915(c) waivers, clarifying that the service limit for Specialized Medical Equipment, Supplies, and Assistive Technology encompasses both Specialized Medical Equipment, Supplies, and Assistive Technology as well as Enabling Technology, i.e., a $10,000 limit per 2 waiver years across both services (detail attached)
    - Adjustments to Nursing Services to assure continuation of direct face-to-face nursing services for skilled nursing tasks at current reimbursement levels (RN and LPN), while increasing the rate of reimbursement for Nursing Services provided by an RN for purposes of Nurse Delegation to $25 per quarter hour and adding additional flexibilities for the provision of Nursing Services by an RN for purposes of Self-Direction of Health Care Tasks (also reimbursed at $25 per quarter hour when provided face-to-face), and the

option for this new Nursing Service component (Nursing Services for Self-Directed Health Care Tasks *only*) to be provided through Telehealth, when appropriate at a rate of $15 per quarter hour (detail attached)

- Adjustments to Personal Assistance services to reflect that such service may include the performance of self-directed health care tasks as permitted under state law and reflected in the PCSP. The rate paid for Personal Assistance will include an additional $1 per hour (25 cents per quarter hour) in pass-through wage incentives for the DSP when such self-directed health care tasks (beyond medication administration) are performed by the DSP as part of the provision of this service when such assistance has been provided by a nurse or would be provided by a nurse due to a change in the person's needs or circumstances
- Adjustments to Therapy (OT, PT, Speech, Language and Hearing), Behavior and Nutrition Services to add the following:
  As part of the provision of this service, licensed professionals shall be expected 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.
  No additional changes are proposed for these benefits as part of this amendment.
- Adjustments to Facility-Based Day Supports to reflect the following:
  Continued authorization of these services shall include an employment informed choice process to support the person in making an informed choice about work and other integrated service options.
- Adjustments to all residential and day services and Personal Assistance to add the following:
  As part of the provision of this service, the provider shall be responsible for working with the person, the person's ISC and Circle of Support to explore how Enabling Technology could be used to support the person's achievement of individualized goals and outcomes and increase the person's independence in or across environments, including home, community, work, volunteering, and travel; helping to educate the person supported and his/her Conservator, as applicable and Circle of Support in order to ensure an informed choice regarding the potential use of Enabling Technology; and the implementation of Enabling Technology supports as part of the delivery of this service, as appropriate, when approved as part of the person's PCSP.
  No additional changes are proposed for these benefits as part of this amendment except as specified herein.

- Clarifying in Appendix C, Quality Improvement: Qualified Providers, c.ii. and other sections as applicable, that with regard to Qualified Provider Reviews and Provider Performance Surveys (typically conducted annually for provider agencies), "there is a 100% biannual review of exceptional or proficient providers."
- Clarifications to the Grievance and Complaint process in Appendix F
- Changes in Appendix G to align critical incident management terms, definitions, and processes across HCBS programs—these are part of broader person-centered system alignment efforts advanced through I/DD integration, but these efforts precede discussions around I/DD integration (critical incident terminology is also changed to reportable event terminology as appropriate throughout the document).
- Slight adjustments in Appendix G pertaining to restraints (included in the above)
- Slight adjustments in Appendix G regarding performance measures, processes, and remediation pertaining to critical incidents and restraints
- Slight adjustments in Appendix H to clarify when a performance measure is reviewed for potential systemic remediation, i.e., based on an overall cumulative compliance percentage below 86% consistently in a quarter over a rolling 12-month period
- Throughout each waiver application, aligning the name used to refer to the plan of care with other HCBS programs: the Person-Centered Support Plan (or PCSP)
- Throughout each waiver application, minor adjustments to conform language across each of the three waivers (as applicable), where such conformity may have been inadvertently overlooked in previous submissions
- Updating references to Bureau of TennCare to Division of TennCare
- Updating outdated references for DIDS (Division of Intellectual Disability Services) to DIDD (Department of Intellectual and Developmental Disabilities)
- Correcting a reference to the "Howard" Jordan Center to "Harold" Jordan Center in the CAC Waiver
- Deleting obsolete references to intake and enrollment in Statewide and Self-Determination Waivers since enrollment into these waivers is closed (only eligible persons institutionalized in the Harold Jordan Center for a period of at least 90 days may qualify to enroll in the CAC Waiver)

The summary of new proposed **changes which were NOT previously included in the prior public notice** includes:

Commented [EI1]: For the Self-Determination Waiver, the person's DIDD Case Manager and applicable only to day services, Semi-Independent Living and Personal Assistance.

- Throughout each waiver application, updating all October 1, 2021 amendment date references to January 1, 2023
- Throughout each waiver application, clarifying existing performance measure language pertaining to data collection/analysis and remediation
- Removing "on-site" from the data source for performance measure AAa.i.8 (inappropriate provider claims identified via post-payment review processes that were appropriately and timely remediated by DIDD and/or the MCO) in Appendix A: Quality Improvement of the Self-Determination waiver to reflect that Fiscal Accountability Reviews may be conducted remotely instead of on-site at the provider agency after the federal Public Health Emergency (PHE) ends. The State is also revising the data source to reflect DIDD Fiscal Accountability Reviews instead of TennCare Utilization Reviews in all three waivers.
- Removing the minimum direct support age requirement of 18 years from the provider specifications under the following services in Appendix C-1:
    - Community Participation
    - Behavioral Respite
    - Enabling Technology
    - Facility-Based Day Supports
    - Family Model Residential Support (CAC and SW Waivers)
    - Individual Transportation
    - Intermittent Employment and Community Integration Wrap-Around Supports
    - Medical Residential Services (CAC and SW Waivers)
    - Non-Residential Homebound Support Services
    - Personal Assistance
    - Residential Habilitation (CAC and SW Waivers)
    - Respite
    - Semi-Independent Living
    - Supported Employment-Individual Employment Support
    - Supported Employment-Small Group Employment Support
    - Supported Living (CAC and SW Waivers)
- Adding language to the Supported Living service definition in Appendix C-1 of the CAC and Statewide waivers to introduce a new flexible residential service rate option to incentivize provider outcomes that align with the State's Value-Based Purchasing (VBP) and System Transformation values
- Revising the Support Coordination definition in Appendix C-1 of the Statewide and CAC waivers to align Support Coordination visit requirements with those in Employment and Community First CHOICES after the PHE and Appendix K flexibilities end.
- Deleting the following language from the Residential Habilitation, Family Model, and Supported Living service definitions in Appendix C-1 of the CAC and SW Waivers per CMS request:
    - ~~RNSA-HB will be available after April 1, 2019 or a later date.~~
- Deleting the following language from the Facility-Based Day Supports, Community Participation, Intermittent Employment and Community Integration Wrap-Around Supports, Non-Residential Homebound Support Services, Supported Employment-Individual, and Supported Employment-Small Group service definitions in Appendix C-1 per CMS request:
    - ~~This service is available beginning January 1, 2020.~~
- Deleting the Employment and Day Services service from Appendix C-1 of the SD waiver
- Deleting the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) background check requirement and adding the System for Award Management (SAM) background check requirement in Appendix C-2.a. Criminal History and/or Background Investigations, C-2.b. Abuse Registry Screening, and C-2.f. Open Enrollment of Providers
- Deleting the minimum direct support age requirement of 18 years from Appendix C-2.f. Open Enrollment of Providers
- Clarifying language in Appendix C-5: Home and Community-Based Settings per CMS request
- Deleting language in Appendix C, Quality Improvement: Qualified Providers related to performance measure QPa.i.b.1 (Number and percentage of non-licensed/non-certified providers who met waiver provider qualifications)
- Deleting language in Appendix C, Quality Improvement: Qualified Providers related to performance measure QPa.a.i.16 (Newly employed/reassigned direct support staff serving waiver participants with federal List of Excluded Individuals/Entities (LEIE) checks completed prior to, but no more than 30 calendar days in advance of employment, or reassignment to direct support)
- Adding a new performance measure and related language in Appendix C, Quality Improvement: Qualified Providers to implement System for Award Management (SAM) as a new background check requirement for

direct support staff.

- Revising language in Appendix D: Service Plan Implementation and Monitoring to align Support Coordination/Case Management visit requirements with those in Employment and Community First CHOICES after the PHE and Appendix K flexibilities end
- Adding language to Appendix D-1: Service Plan Development to include electronic signature as an additional option for the person supported and legal representative, as applicable, to approve the PCSP
- Adding a new performance measure and related language in Appendix D: Quality Improvement under Sub-Assurance a (Methods for Discovery: Service Plan Assurance/Sub-assurances) to address whether service plans meet the individual's needs as recommended by CMS
- Updating the sampling methodology in Appendix D: Quality Improvement for performance measure SPa.i.a.4 (Number and percentage of consumer satisfaction survey respondents who reported that the things important to them were addressed in their Person-Centered Support Plan) to reflect a calendar year stratified sample with a minimum seven percent (7%) completion across all waivers
- Moving performance measure HWa.i.1 (Number and percentage of waiver participants who received medical exams in accordance with TennCare Rules) in Appendix G: Quality Improvement from Sub-assurance a to Sub-assurance d per CMS request
- Adding a new performance measure and related language in Appendix G: Quality Improvement under Sub-Assurance a (Methods for Discovery: Health and Welfare) to address whether individuals know how to report abuse, neglect, and exploitation as recommended by CMS
- Updating the sampling methodology in Appendix G: Quality Improvement for HWa.i.2 (Number and percentage of participant satisfaction survey respondents who indicated knowledge of how to report a complaint), HWa.i.3 (Number and percentage of participant satisfaction survey respondents who reported being treated well by direct support staff), and HWa.i.4 (Number and percentage of participant satisfaction survey respondents who reported having sufficient privacy) to reflect a calendar year stratified sample with a minimum seven percent (7%) completion across all waivers
- Revising performance measure HWa.i.8 in Appendix G: Quality Improvement to reflect both DIDD and provider level investigations by removing the "DIDD" specification
- Removing "on-site" references in Appendix I-1 to reflect that Fiscal Accountability Reviews may be conducted remotely instead of on-site at the provider agency after the PHE ends
- Adjustments to Appendix I-1: Financial Integrity and Accountability language to reflect the transition of Independent Audit oversight responsibilities from DIDD to the MCOs.
- Updating performance measures and language in Appendix I: Quality Improvement pertaining to FAa.i.1 and FAa.i.4
- Adding language to Appendix I-2 of the CAC and Statewide waivers to introduce a new flexible residential service rate option to incentivize provider outcomes that align with the State's VBP and System Transformation values
- Adding the VBP Flexible Residential Rate service component in Appendix J-2 of the CAC and Statewide waivers under the Supported Living service
- Deleting the Employment and Day Services service from Appendix J of the SD Waiver
- Updating Appendix J projections for waiver years 2023 and 2024 of the CAC and SW Waivers
- Submitting Appendix J projections for wavier years 2023 through 2027 of the SD Waiver

Details regarding each of these changes follows below, as needed. Language in the CMS waiver application template sections is in blue font. Currently approved waiver language is in black font. Tracked changes representing the I/DD Integration amendment changes posted for public comment in 2021 are shown in ~~struck-through~~ red font for deleted text and violet underline font for new text. Tracked changes representing new proposed waiver changes that were NOT posted for public comment in 2021 are in ~~struck through~~ pink font for deleted text and green underline font for new text.

I. 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 MCO responsibilities under the waiver

Appendix A: Waiver Administration and Operation

1.b Medicaid Agency Oversight of Operating Agency Performance will be modified as follows:

The Statewide (SW) Waiver is operated by the Department of Intellectual and Developmental Disabilities (DIDD) through an interagency agreement with the Division of TennCare, Department of Finance and Administration.

The Tennessee Department of Finance and Administration is designated as the Single State Medicaid Agency for the State of Tennessee. The Division of TennCare is the state's medical assistance unit and is located within the Department of Finance and Administration. The TennCare Director, who serves as a Deputy to the Commissioner of the Department of Finance and Administration, is the State Medicaid Director and exercises legal authority in the administration and supervision of the Medicaid State Plan and the TennCare 1115 Demonstration Waiver, and issues policies, rules and regulations on program matters. TennCare is accountable for oversight of this waiver program and retains the responsibility for policies and promulgation of rules governing this waiver.

DIDD is responsible for the operational management of the waiver on a day-to-day basis and is accountable to the State Medicaid agency which ensures that the waiver operates in accordance with federal waiver assurances.

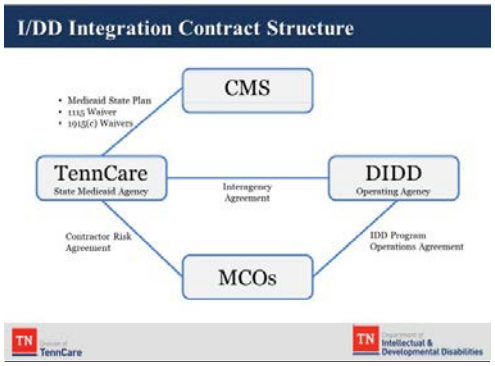
As part of proposed amendments to integrate and transform programs and services for individuals with I/DD, HCBS provided under this waiver will become part of the managed care program. Each waiver participant's currently assigned Managed Care Organization (MCO)— already charged with administering their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

The relationship between TennCare, DIDD, and the MCOs will be established and outlined within three documents: the Interagency Agreement between TennCare and DIDD, the Contractor Risk Agreement between TennCare and the MCOs, and the Program Operations Agreement between DIDD and the MCOs.

As the federally designated State Medicaid Agency, TennCare will continue to contract with DIDD to serve as the operational lead agency for this waiver. The interagency agreement between TennCare and DIDD outlines the roles and responsibilities of DIDD and TennCare's expectations of DIDD in relation to oversight and enforcement of the MCOs.
TennCare is primarily responsible for policy making and DIDD is responsible for implementation of policies and oversight.

TennCare will also continue to maintain a Contractor Risk Agreement with MCOs encompassing the broader TennCare program requirements, including physical and behavioral benefits, as well as LTSS. All policies, procedures, and guidelines issued by the MCO are based on the expectations and requirements of the State Medicaid Agency as set forth in the Contractor Risk Agreement with the MCOs.

DIDD will enter into a separate I/DD Program Operations Agreement with MCOs. The Program Operations Agreement, developed by TennCare, will clearly define DIDD's authority in leading the day-to-day management and oversight of the MCO contracts for I/DD benefits. Through this Agreement, DIDD will oversee and enforce the State Medicaid Agency's expectations and requirements as set forth in the CRA.



~~Responsibility is delegated to DIDD and monitored by TennCare for level of care reevaluations, development of the ISP, prior authorization of waiver services, enrollment of qualified providers, and certain quality assurance activities.~~

TennCare exercises administrative authority and supervision of ~~these~~ operating functions delegated to DIDD through the interagency agreement which is reviewed on an annual basis to ensure that it accurately reflects expectations and incorporates any program changes implemented as a result of recent waiver amendments or changes in state or federal requirements. ~~-~~TennCare promulgates state waiver rules and directs ~~approves~~ all documents pertaining to daily operational management of the waiver prior to their issuance and implementation, including (but not limited to): all ~~DIDD~~ policies and procedures, Provider Manual revisions, provider rate changes, and ~~mass~~ formal communications (e.g., notices) to providers and persons supported. TennCare exercises administrative authority and supervision of operating functions delegated (in part) to MCOs through the Contractor Risk Agreement which is reviewed and updated at least semi-annually. DIDD will assist TennCare in this oversight as prescribed both in the interagency agreement and the I/DD Program Operations Agreement.

In addition to reporting requirements described in the Interagency Agreement and MCO Contractor Risk Agreement and ongoing informal communication processes, ~~monthly~~ frequent meetings between TennCare, ~~and~~ DIDD, and MCOs ensure adequate TennCare oversight. ~~Monthly~~ These meetings include:

- ~~The Interagency~~ I/DD Executive and Senior Leadership Meeting: Executive and Senior leadership of TennCare, ~~and~~ DIDD, and MCOs meet on a~~t least a monthly~~ frequent basis to discuss issues pertaining to operation and oversight of this (and other) HCBS waiver program(s) for individuals with intellectual disabilities.

- The Interagency Compliance Meeting. TennCare and DIDD staff meet to discuss the oversight and enforcement activities performed by DIDD and any concerns regarding DIDD or MCO compliance with contractual responsibilities.

- ~~The Policy Meeting: TennCare and DIDD staff review DIDD policies and stakeholder memorandums under development, including the status of those under review at TennCare; Provider Manual revisions; changes in TennCare rules and policy; and the status of waiver applications or amendments, as applicable. This forum is also used as a mechanism for DIDD to obtain TennCare policy interpretations and for TennCare to assign responsibility for CMS deliverables.~~

- The Statewide Continuous Quality Improvement Meeting: DIDD, ~~and~~ TennCare ~~LTSS Quality and Administration staff~~, and MCO staff review ~~identified~~ data and ~~reporting issues, as well as~~ findings resulting from DIDD and TennCare Quality Assurance activities (e.g., targeted Reviews, utilization reviews, fiscal audits) and ~~discuss~~ determine appropriate corrective actions.

- ~~The Abuse Registry Review Committee Meeting: A TennCare representative serves on the Abuse Registry Review Committee and participates in the review of substantiated allegations of abuse, neglect, and exploitation. The committee decides when individuals will be referred for placement on the Tennessee Department of Health Abuse Registry.~~

- The Statewide and Regional Planning and Policy Council Meetings: DIDD and TennCare staff participate in statutorily required meetings with stakeholders including persons supported and their family members, a variety of provider representatives enrolled as waiver service providers (e.g., clinical service providers, residential/day providers and/or support coordination providers), representatives from persons supported and provider advocacy organizations, and other stakeholders. Planning and Policy Council members are routinely advised of expected changes in policy, provider requirements, and provider reimbursement; waiver application and amendment status; HCBS program expenditures and the state's budget situation; and other issues impacting service delivery and program operations. The Council makes recommendations to the State regarding program and policy improvements.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

☒ Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform.

Effective ~~July 1, 2021~~ January 1, 2023, the HCBS provided under this waiver will become part of TennCare's managed care program pursuant to concurrent 1115 demonstration authority. TennCare will contract with existing Medicaid MCOs to perform specified administrative functions pertaining to this waiver program. Initially, these will include primarily contracting with qualified providers to deliver waiver services and processing and paying claims for waiver services. Over time (TBD) additional administrative functions will be transitioned from DIDD to MCOs pursuant to the Interagency Agreement, Contractor Risk Agreement, and Program Operations Agreement, with ongoing oversight by DIDD and by TennCare. These may include review of person-centered support plans, utilization management, and authorization of waiver services pursuant to the approved PCSP. While DIDD will provide leadership and direction in quality assurance and improvement efforts, MCOs will also play a role in quality assurance and quality improvement activities pertaining to these services that will be further described in the Quality Performance and Improvement Strategy submitted for the 1115 Demonstration.

6. Assessment Methods and Frequency is modified to "Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:"

TennCare will oversee MCOs assigned operational and administrative functions through detailed requirements set forth in the Contractor Risk Agreement, reporting requirements specified therein, audit processes, and other activities detailed in the comprehensive Quality Performance and Improvement Strategy for the TennCare demonstration. Monitoring of claims processing is also conducted by the Tennessee Department of Commerce and Insurance.

All TennCare MCOs are required to be accredited by the National Committee on Quality Assurance encompassing a comprehensive framework for quality measurement and improvement across areas such as:

- Quality Management and Improvement
- Network Management
- Utilization Management
- Credentialing and Recredentialing

Under DIDD's Interagency Agreement with TennCare, DIDD will perform day-to-day oversight of MCO contracted functions pertaining to these waivers, using reports, audits, and other processes to assure compliance and to identify and coordinate with TennCare to address performance concerns.

7. Distribution of Waiver Operational and Administrative Functions is modified to reflect distribution of administrative functions among TennCare, DIDD, and MCOs. For most functions, multiple entities will be involved. For some functions, MCOs will not *initially* have responsibility—such as reviewing service plans, prior authorization of waiver services, and utilization management. Once these functions transition from DIDD to the MCOs (at a date TBD), DIDD will continue to exercise day-to-day oversight of these functions, with TennCare exercising administrative authority and supervision, as is required (see below).

In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☑	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐
Waiver expenditures managed against approved levels	☑	☑	☑
Level of care evaluation	☑	☑	☐
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☐	☑	☑
Utilization management	☑	☑	☑
Qualified provider enrollment	☑	☑	☑
Execution of Medicaid provider agreements	☑	☐	☐
Establishment of a statewide rate methodology	☑	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

a.i. Methods for Discovery: Administrative Authority will be modified to add the MCO as an entity who may also be responsible for remediation of individual findings specified in these measures and TennCare's administrative oversight of these remediation activities.

Performance Measure
a.i.3. Number and percentage of individual findings regarding provider (including staff) qualifications that were appropriately and timely remediated by DIDD and/or the MCO. [Interagency Contract section A.1.n & A.2.a.(2)] Percentage = number of provider qualification issues appropriately and timely remediated / total number of provider qualification issues identified.
a.i.7. Number and percentage of substantiated cases of abuse, neglect and exploitation that were appropriately and timely remediated by DIDD and/or the MCO. [Interagency Contract section A.2.a.] Percentage = number of substantiated cases of abuse, neglect, and exploitation appropriately and timely remediated / total number of substantiated cases of ANE.
a.i.4. # and % of individual findings regarding Individual Support Plans that were appropriately and timely remediated by DIDD and/or the MCO. [Interagency Contract section A.1.g & A.1.i] Percentage = # of individual findings regarding Individual Support Plans that were appropriately and timely remediated/ total # of individual findings regarding Individual Support Plans.

a.i.6. # & % of waiver participants not offered choice (i.e., of waiver versus institutional services, of waiver services, and of qualified service providers) for whom remediation was appropriately and timely completed by DIDD and/or the MCO. [Interagency Contract sec. A.1.d & A.2.d.(2)] % = # of participants not offered choice with appropriate and timely remediation/total # of participants not offered choice.
a.i.2. Number and percentage of individual findings regarding level of care reevaluation that were appropriately and timely remediated by DIDD and/or the MCO. [Interagency Contract section A.1.h.] Percentage = number of level of care reevaluation findings appropriately and timely remediated / total number of level of care reevaluation findings identified.
a.i.8. Number and percentage of inappropriate provider claims identified via post-payment review processes that were appropriately and timely remediated by DIDD and/or the MCO. [Interagency Contract section A.2.b.] Percentage = number of individual inappropriate claims appropriately and timely remediated / total number of inappropriate claims identified via post-payment review processes.
~~a.i.1. Number and percentage of waiver policies/procedures developed by DIDD that were approved by TennCare prior to implementation. [Interagency Contract section A.1.b.] Percentage = number of waiver policies/procedures approved by TennCare prior to implementation / total number of waiver policies/procedures implemented.~~

Commented [EI2]: Deleted as TennCare will develop all waiver policies/procedures under the managed care program.

The State is revising the data source for performance measure a.i.8:

Data Source (select one):

Record reviews~~, on-site~~

If Other is selected, specify:

~~TennCare Utilization Review Findings~~ DIDD Fiscal Accountability Reviews

Subsection b.i. Methods for Remediation/Fixing Individual Problems will also be modified as follows:

~~Performance Measure a.i.1: The TennCare Interagency Agreement specifies that DIDD may not implement policy prior to TennCare approval. TennCare policy reviews will be documented in the TennCare Policy Review Log as well as in DIDD Monthly Quality Management and Discovery Reports. Each DIDD policy distributed notes the date of TennCare approval within the document. TennCare will monitor compliance with this sub-assurance through analysis of monthly data reports, information presented during monthly TennCare/ DIDD meetings, and other quality assurance activities (e.g., survey follow-along or follow-behind, audits) conducted as determined appropriate. Upon discovery of a policy that was not prior approved, TennCare will provide written notification to DIDD that the policy must be submitted to TennCare for approval and will not be effective until such approval is obtained. TennCare will perform a review of the new or revised policy, and will advise DIDD if additional revisions are needed as a result of TennCare review. Approval will be granted when TennCare requested final edits have been made. The effective date of an approved new or revised policy will be a date after TennCare approval is obtained, unless TennCare determines it appropriate to approve the policy for a retroactive date. Failure to obtain policy prior approval will be brought to the attention of the DIDD Commissioner, the DIDD Assistant Commissioner of Policy and Innovation, and other DIDD staff, as applicable. TennCare may assess monetary sanctions against DIDD, require additional DIDD staff training, conduct additional monitoring and/or require the submission of additional data to ensure 100% compliance with this sub-assurance.~~

Performance Measure a.i.2 through a.i.8: Issues requiring individual remediation will be discovered primarily through analysis of DIDD performance measure discovery data files and DIDD Quality Management Reports or MCO reports, as applicable. TennCare will hold DIDD and/or the MCOs accountable for timely remediation of all individual issues identified. TennCare routinely monitors DIDD monthly remediation reports and MCO reports to determine if acceptable remedial activities have been completed. DIDD or the MCOs, as applicable, is notified monthly of any remediation determined unacceptable and is required to provide additional information and/or complete additional remediation activities until TennCare can determine that the issue has been resolved. DIDD and the MCOs are ~~is~~ required to remediate all individual issues identified within a targeted time-frame of 30 calendar days. Remediation Reports contain data indicating the number of compliance issues for which remediation was completed within 30 calendar days.

MCO reports are specified in the Contractor Risk Agreement and submitted through the TennCare deliverables tracking system.

b.ii. of this Subsection will be modified to add the MCOs as an entity who may also be responsible for remediation-related data aggregation for certain measures.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations will be modified as follows:

Any staff person who has direct contact with or direct responsibility for the person supported must pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD) and must not be listed on the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender List, or the ~~Office of Inspector General List of Excluded Individuals and Entities~~ System for Award Management (SAM).

b. Abuse Registry Screening will be modified as follows:

The Tennessee Department of Health maintains the State's Abuse Registry under the authority of T.C.A. 68-11-1001, et seq. The provider agreement requires that each provider have background and registry checks completed for all new employees whose responsibilities include direct care for a person supported and any current employees who have a change in job responsibilities to include direct care for a person supported, prior to, but no more than 30 calendar days in advance of, employment or a change in duties. This requirement includes specifically: (1) an appropriate background check completed by either the Tennessee Bureau of Investigation or a company licensed by the state to conduct such checks; (2) a check of the Tennessee Department of Health Abuse Registry; (3) a check of the

Tennessee Sexual Offender Registry; (4) a check of the Tennessee Felony Offender List; and (5) a check of the ~~Office of Inspector General List of Excluded Individuals and Entities~~ System for Award Management.

Furthermore, DIDD conducts monthly checks of the ~~Office of Inspector General List of Excluded Individuals and Entities~~ System for Award Management for all providers and sends the monthly reports directly to TennCare Program Integrity.

C-2: General Service Specifications (3 of 3)

f. Open Enrollment of Providers will be modified as follows:

With the integration of waiver services into managed care and pursuant to concurrent 1115 waiver authority, MCOs will be responsible for contracting with an adequate network of providers to deliver waiver services.

DIDD will serve in a credentialing role for all HCBS provider types (with the exception of Adult Dental Services). Upon transition of the management of Adult Dental Services, TennCare's contracted Dental Benefits Manager will credential Dental providers, with oversight by TennCare and DIDD.

Effective ~~July 1, 2021~~January 1, 2023, currently qualified and contracted providers in the 1915(c) waivers will be deemed by DIDD as credentialed for participation in managed care. MCOs will abide by the "deemed" status, and will not establish additional requirements or credentialing processes or standards for participation in the MCOs' network. To ensure continuity of waiver services and choice of providers in accordance with the approved PCSP, MCOs will offer a provider agreement effective ~~July 1, 2021~~January 1, 2023, to all qualified 1915(c) waiver providers contracted with TennCare and DIDD.

New providers will be credentialed by DIDD using standards established in partnership with DIDD and MCOs, with input from I/DD stakeholders.

Providers will be periodically re-credentialed by DIDD using standards established in partnership with DIDD and MCOs.

Consistent with the principles of managed care, to ensure that MCOs maintain flexibility to drive quality performance and outcomes, beginning on or after ~~July 1, 2022~~ January 1, 2023 as directed by TennCare (which may vary by service type), except for continuity of care and with the potential exception of ISC agencies during an evaluation phase, MCOs may contract with any 1915(c) waiver provider credentialed (or re-credentialed) by DIDD as meeting qualifications for the delivery of specified services provided that the MCO must maintain an adequate network to initiate and consistently deliver services in accordance with each member's PCSP, including Support Coordination. 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.

~~TennCare and the Department of Intellectual and Developmental Disabilities (DIDD) allow for enrollment of all willing and qualified providers of waiver services during recruitment cycles. The DIDD web site provides information to interested providers regarding the DIDD enrollment process; which includes obtaining a provider application, Applicant Forums and information regarding Open and Targeted Enrollment (recruitment cycles). Information regarding the provider enrollment process, provider qualifications for waiver services and other helpful information is also available to prospective services on the DIDD website and by contacting designated staff at DIDD whose contact information is posted online. All information and forms mentioned are available at all times to potential providers.~~

~~All applications submitted by providers are reviewed by DIDD and submitted to TennCare for enrollment as a waiver provider if the specified qualifications are met.~~

~~Prospective providers are given the opportunity to respond to any questions or additional information requested to complete the application. DIDD staff are available to address any questions the prospective provider may have regarding the application process.~~

In addition to the provider qualifications specified in Appendix C-1 for each HCBS service, the following general requirements apply to all providers of waiver services:

- ~~All providers shall be at least 18 years of age.~~
- Staff who have direct contact with or direct responsibility for the person supported shall not be listed in the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender List, or the ~~Office of Inspector General List of Excluded Individuals and Entities~~ System for Award Management.

Commented [EI3]: Applicable only for Statewide and CAC waivers, not Self-Determination. Support Coordination will continue to be performed as an Administrative function by DIDD Case Managers in the Self-Determination Waiver.

Appendix C: Participant Services
Quality Improvement: Qualified Providers

The State is adding the following new performance measure:

Data Source (Select one):

Other

If 'Other' is selected, specify:

DIDD Qualified Provider Reviews

a.i.a. Newly employed/reassigned direct support staff serving waiver participants with System for Award Management (SAM) checks completed prior to, but no more than 30 calendar days in advance of employment, or reassignment to direct support. % =# of newly employed/reassigned DSS with timely SAM checks/total number of newly employed/reassigned DSS serving waiver participants.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☑ Monthly	☐ Less than 100% Review
☐ Other Specify:	☐ Quarterly	☐ Representative Sample Confidence Interval:
	☐ Annually	☐ Stratified
	☐ Continuously and Ongoing	☐ Other
	☐ Other Specify:	

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Performance Measures a.i.a.4., a.i.a.5. through a.i.a.11., ~~a.i.b.1~~ and a.i.c.1.: Qualified Provider Reviews and Provider Performance Surveys are conducted annually for 100% of provider agencies who employ two (2) or more staff.

Note: The State added a.i.a.~~15~~ to reflect ~~the ongoing~~ a new requirement that newly employed (or reassigned) direct support staff serving waiver participants (persons supported) have ~~federal List of Excluded Individuals/Entities (LEIE)~~ System for Award Management (SAM) checks completed prior to, but no more than 30 calendar days in advance of employment, or a change in assignment to direct support.

Commented [EI4]: Pending new performance measure number

Commented [EI5]: Pending new performance measure number

b. Methods for Remediation/Fixing Individual Problems

Performance Measure a.i.a.1.: Providers who do not meet the requirements specified in these performance measures will not be deemed as credentialed by DIDD, allowed to sign a Provider Agreement with an MCO, enroll in ~~the~~ an ~~DIDD,~~ MCO's provider network, ~~, and/or TennCare MMIS claims processing systems,~~ or receive payment for services rendered. Applications for credentialing that do not meet requirements will be denied.

Performance Measure a.i.a.4.: When DIDD identifies that an existing provider has not maintained required licensure/certification, DIDD will notify the MCOs and TennCare within two (2) working days so that funds may be recouped for payment of any past period during which services were billed while the provider qualifications were not met. The MCO Provider Agreement will be terminated unless proof of licensure/certification is submitted to DIDD within 30 days of the date the issue was identified.

Performance Measures a.i.a.5. through a.i.a.8., a.i.a. and a.i.c.1.: DIDD will review a sample of provider agency staff personnel and training records during Qualified Provider Compliance Reviews. For individual direct support staff who did not have required training, at the time of the Qualified Provider review, DIDD will require the provider agency to take appropriate personnel action(s).

Failure to obtain and maintain background or registry checks and/or staff training in accordance with state law and DIDD requirements and/or failure to take appropriate personnel actions may result in provider sanctions, including institution of a moratorium on serving new waiver participants.

Commented [EI6]: Pending new performance measure number for SAM checks

Performance Measure a.i.a.10.through a.i.a.11.: DIDD will review a sample of provider agency staff personnel records during Qualified Provider Compliance Reviews.

~~Performance Measure a.i.b.1.: Non-licensed/non certified providers who do not meet provider qualifications will be subject to termination of their Provider Agreement unless identified issues can be resolved within 30 days of the date of discovery. DIDD will notify TennCare within two (2) working days of any lapse in meeting provider qualifications, so that payment may be recouped for service reimbursed during the time period when qualifications were not met. The provider will not be able to receive reimbursement for additional services provided prior to the date when provider qualification issues are resolved.~~

Appendix C-5: Home and Community Based Settings language i s modified as follows:

~~Specific setting types include all residential and non-residential and include all the following services which are re-assessed annually as part of the Quality Monitoring process: Facility-Based Day Supports, Community Participation Supports, Supported Employment (Individual and Small Group Employment Support), Intermittent Employment and Community Integration Wrap-Around Supports, Non-Residential Homebound Support Services, Supported Living, Residential Habilitation, Medical Residential Services, and Family Model Residential Support. All settings in which HCBS are provided, and not otherwise included in the HCB Settings Transition Plan for this waiver, comport with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes. Exceptions to these requirements are made only when supported by the individual's specific assessed need and specified in the person-centered ISP.~~ An individual may reside in his/her own home, the home of a family member or other person of his/her choosing, or a shared living arrangement where residential supports are provided. These include: Supported Living, Residential Habilitation, Medical Residential Services, and Family Model Residential Support.

In addition to shared residential settings, specific settings to which the HCBS settings rule apply include any settings where the following services are provided: Facility-Based Day Supports, Community Participation Supports, Supported Employment (Individual and Small Group Employment Support), Intermittent Employment and Community Integration Wrap-Around Supports, and Non-Residential Homebound Support Services.

All settings in which HCBS are provided~~, and not otherwise included in the HCB Settings Transition Plan for this waiver,~~ comport with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes.

Exceptions to these requirements are made only when supported by the individual's specific assessed need and specified in the ~~person-centered ISP~~PCSP.

Each setting has been reviewed as part of the State's assessment process, and has been determined to be in compliance as part of the State's completed implementation of its CMS-approved Statewide Transition Plan, including heightened scrutiny review process, by March 17, 2019. These settings are re-assessed annually as part of the Quality Monitoring process.

All individual goals and objectives, along with needed supports to progress toward, achieve or sustain these goals and objectives, are established through the person-centered planning process and documented in the ~~person-centered ISP~~PCSP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the person supported.

The Interagency Agreement between TennCare and DIDD for operation of these waivers, Contactor Risk Agreement between TennCare and MCOs, and I/DD Program Operations Agreement between DIDD and MCO includes HCBS Settings Rule compliance, as do MCO Provider Agreements. Each provider is assessed at a minimum, at enrollment, and during the quality assurance survey process to ensure that each service is being delivered to all persons supported in a manner that comports with federal waiver assurances, and the HCBS settings rule. Compliance at the individual member level will continue to be assessed through oversight of the person-centered planning process and review of member experience data. An assessment of each person's experience is embedded into the person-centered planning process on an ongoing basis to ensure that services and supports received by that person are non-institutional in nature, and consistent with the requirements and objectives of the HCBS settings rule. This is conducted by the Independent Support Coordinator, or Case Manager, as applicable, as part of the person's annual person-centered plan review. This assessment is intended to measure each individual's level of awareness of and access to rights provided in

the HCBS Settings Rule, freedom to make informed decisions, community integration, privacy requirements, and other individual experience expectations as outlined in the HCBS Settings Rule. DIDD reviews assessment responses for all Medicaid recipients receiving services in this waiver and investigates each "No" response that indicates a potential area of non-compliance or potential rights restriction to determine if the provider is in compliance with the HCBS Settings Rule, and with respect to restrictions, to ensure the restriction has gone through the HCBS Settings Rule modifications procedure and is appropriately included in the person-centered support plan. If the restriction has not gone through the modification process and is not supported in the person-centered support plan, DIDD remediates the concern by working with the provider and the person supported and his or her representative, if applicable. ~~with providers, TennCare, and DIDD. In addition, HCBS Settings Rule language has been added to the DIDD Provider Manual that sets requirements related to individual rights and modifications to the Rule.~~ DIDD will continue to monitor provider compliance with HCBS Settings requirements and will work with MCOs and ISCs to promptly address remediation of any identified concerns.

II. Person-centered updates in Support Coordination processes and expectations, including an Employment Informed Choice process

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

~~As part of the enrollment process into the waiver, DIDD intake staff advise and explain to the individual or person legally authorized to act on behalf of the individual (as applicable), the operation of the waiver program and waiver services offered as an alternative to care in an Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID), including the person's right to direct the person-centered planning process.~~

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.

This is a positive approach to the planning and coordination of services and supports based on individual strengths, needs, and goals, in a manner that reflects individual preferences and values, and is driven by individual choice. The goal of person-centered planning is to create a plan that optimizes the person's self-defined quality of life, choice, and control, and self-determination through meaningful exploration and discovery of unique preferences, needs and wants in areas including, but not limited to, health and well-being, relationships, safety, communication, residence, use of enabling technology, community, resources, and assistance. The person must be empowered to make informed choices that lead to the development, implementation, and maintenance of a flexible service plan for paid and unpaid services and supports in the most integrated setting that reflects personal preferences and choices.

As part of the scope of services for Support Coordination, ISCs are charged with:

- Supporting the individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
- Assuring the personal rights of freedoms of persons supported, and supporting dignity of choice, including the right to exercise independence in making decisions, and facilitation of supported decision making when appropriate;
- Identification and mitigation of risks to help support personal choice and independence, while assuring health and safety; and
- Specific documentation of any modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes prescribed in federal and state regulation and protocol.

Commented [EI7]: DIDD Case Manager for Self-Determination Waiver

Commented [EI8]: For Self-Determination Waiver, this will say, "administration of support coordination by DIDD, Case Managers are charged with… "

The ISC will provide the individual with information about self-advocacy groups and self-determination opportunities and assist in securing needed transportation supports for these opportunities when specified in the PCSP or upon request of the individual.

The PSCP template includes a section which identifies the supports the person will need for person-centered planning and for decision making and identifies who they want to include in the person-centered planning process.

~~c. The intake staff should discuss with the person and any legally authorized representative, the supports the person will need to engage in the development of the initial ISPPCSP, and will help to arrange for such supports, and actively engage the person and others he or she designates in the development of the initial ISPPCSP. Intake staff will review the PreAdmission Evaluation (PAE) as applicable and the initial ISPPCSP with the person and his representative, provide a list of available service providers with contact information, and answer any questions related to the waiver. The intake staff person will provide information, including a copy of the Family Resource Guide, to the person supported or person's family representative. The Family Resource Guide is a guide available to support services for family members of individuals with intellectual disabilities. The intake staff are also expected to share information about non-state services and supports such as community resources, etc.~~

~~Once enrolled in or transferred to the waiver, all persons supported have an assigned Independent Support Coordinator (ISC) who is responsible for facilitating the person-centered planning process, always driven by the person supported, and directed by the person supported, as appropriate and with supports as needed. The person-centered planning process results in the development of the ISPPCSP; ensuring that person-centered planning process is driven by the person supported, as appropriate; services are initiated within required time frames; and conducting ongoing monitoring of the implementation of the ISPPCSP and the person's health and welfare.~~

~~Person-centered planning is individual-directed and may include a representative whom the individual has freely chosen, and others chosen by the individual to contribute to the process.~~

~~The Independent Support Coordinator is responsible for providing necessary information and support to the individual to support his/her direction of the person-centered planning process to the maximum extent desired and possible. The person supported has the authority to decide who is included in the development of the PCSP (PCISP).~~

Commented [EI9]: DIDD CM for SD waiver

Appendix D: Participant Services

D-1 Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Independent Support Coordinators (ISCs) assist persons supported in ~~identifying their needs and preferences and selecting, obtaining and coordinating services using paid and natural supports~~ developing the person-centered support plan (PCSP). The process is directed by the individual to the greatest extent possible and desired, and includes the person, his or her ~~The~~ ISC, in collaboration with the person supported, the person ~~supported~~ authorized representative (if applicable), and other persons specified by the person supported (such as ~~this may include~~ family members, friends, and paid service providers selected by the person). The group—often referred to as a Circle of Support— convenes at time and location convenient to the person supported, ~~in a formal Planning Meeting to discuss and finalize the ISP~~PCSP ~~which is the person-centered support p~~lanISP.. ~~Each person-centered planning process must:~~

~~a. Be directed by the individual to the greatest extent possible,~~

~~b. Identify strengths and needs, both clinical and support needs, and desired outcomes,~~

~~c. Reflect cultural considerations and use language understandable by the individual~~

~~d. Include strategies for solving disagreements~~

~~e. Provide method for individual to request updates to be made to their ISP~~PCSP

(b) The policy and procedures which define and guide the person-centered planning process and assure that people chosen by the individual supported are integrally involved in the development of an ~~ISP~~PCSP that reflects their preferences, choices, and desired outcomes provide for:

- ~~a.~~ An assessment of the individual's status, adaptive functioning, and ~~service~~ support needs through the administration of a uniform assessment instrument (~~such as~~ the Supports Intensity Scale) and the collection of other information relevant to the person's support needs;
- ~~b. An assessment~~ Initial and ongoing assessment of how Enabling Technology could be used to support the person's the person's increased independence in their home, community, and workplace and the achievement of individualized goals and outcomes;~~process which identifies how Enabling Technology supports an individual's increased independence in their home, community, and workplace.~~
- ~~c.~~ The identification of individual risk factors through the administration of a uniform risk assessment, identification of person-centered strategies to mitigate risks, and clear communication with the person supported and/or his/her representative, as applicable, regarding potential risks and ways to mitigate risks to support an informed decision regarding whether the risk, as mitigated, is tolerable, including documentation of the person's decision in the ~~ISP~~PCSP;

Commented [EI10]: Section below revised to better align with the requested sections above and to reflect person-centered updates in support coordination expectations and processes

Commented [EI11]: DIDD Case Managers for Self-Determination Waiver

Commented [EI12]: Same as above

- ~~d~~c. Additional assessments, where appropriate, by health care professionals (e.g., occupational or physical therapists, behavior analysts, etc.);~~;~~
- Additional information about participant needs, preferences and goals, and health status are gathered as part of the person-centered planning process, including ~~e~~d. ~~T~~the identification of personal outcomes, ~~support~~ goals, supports and services needed, information about the person's current situation, including health status, what is important to and for the person supported, and changes desired in the person's life (e.g., home, work, relationships, community ~~membership~~ engagement, health and ~~wellness~~ wellness, etc.~~)~~; and ~~(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.);~~

~~f. An employment informed choice process with the expectation of exploring employment and supporting the person to make informed choices about work and other integrated service options, clearly prioritizing community integration over home-based or facility-based supports.~~

- ~~g.~~ At least annual assessment of the individual's experience to confirm that that the setting in which the individual is receiving services and supports comports with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the ~~person-centered ISP~~PCSP.~~; and~~

(c) The participant is informed of the services that are available under the waiver by the ISC as part of the person-centered planning process. This includes a "plain language" explanation of these benefits as part of educational materials developed by TennCare and included in the MCO Member Handbook.

(d) The template developed by TennCare and used to develop the PCSP ensures that the service plan addresses participant goals, needs (including health care needs), and preferences. ISCs are expected to coordinate with the person's MCO regarding access to physical and behavioral health services needed to address health care needs and achieve health and wellness goals. ~~fh. Waiver and other services are coordinated by the ISC through the development and implementation of the ISPPCSP. The ISPPCSP describes all the supports and services necessary to support the person to achieve their desired outcomes and attain or maintain a quality life as defined by them, including services that may be provided through natural supports, the Medicaid State Plan or pursuant to the person's Individual Education Plan (IEP).~~

The ~~ISP~~PCSP development process includes the following: identification of personal outcomes, ~~support goals~~, supports and services needed, information about the individual's current situation, what is important to and for the individual, and changes desired in the person's life (e.g., home, work, relationships, community membership, health and wellness), supporting the individual's informed choice regarding services and supports they receive, providers of such services, and the setting in which services and supports are received and which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS; and specific documentation of any modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes prescribed in federal and state regulation and protocol.

Commented [EI13]: DIDD Case Manager for Self-Determination waiver

~~As required pursuant to the federal Personal Centered Planning Rule, the ISP shall be signed by the individual and all persons involved in implementing the plan, including those providing paid and or unpaid supports.~~

(e) The ISC is responsible for coordinating waiver and other services and supports identified in the PCSP. This may include but is not limited to coordination with the MCO (or with Medicare or the person's Medicare Advantage Plan, as applicable) and with physical and behavioral health care providers and HCBS providers to improve and maintain health, support personal health and wellness goals, manage chronic conditions, and ensure timely access to and receipt of needed physical and behavioral health services; coordination with Vocational Rehabilitation Services or the Local Education Authority, as applicable; and coordination with local community organizations and others as needed to address social determinants and help to sustain community living;

(f) The PCSP will clearly identify the entity responsible for each of the actions identified in the PCSP. Providers will be expected to develop an implementation plan as needed to further define specific expectations around how the PCSP will be implemented to achieve the person's individualized goals. As required pursuant to the federal Personal Centered Planning Rule, the PC~~I~~SP will be signed by the individual and all persons involved in implementing the plan, including those providing paid and or unpaid supports.

The use of e-signatures that meets privacy and security requirements will be added as a method for the participant or legal guardian signing the PCSP to indicate approval of the plan. Services may start while waiting for the signature to be returned to the ISC/Case Manager, whether electronically or by mail. Signatures will include a date reflecting the PCSP meeting date. ISCs will be responsible for the implementation and monitoring of the PCSP (with oversight from DIDD).

(g) The PCSP will be updated at least annually or based on a change in the person's needs or circumstances or based on the request of the person supported.

~~The ISPPCSP 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 will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the person's disability and are responsive to the person's needs and preferences. Ongoing monitoring by ISCs is accomplished through a stratified approach, based on level of support need, as follows: 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 a minimum of at least one monthly in-person or telephone contact and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home. A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires a minimum of at least one monthly face-to-face contact across all environments and in the person's residence at least quarterly. Residential level of reimbursement is the overriding determinant of the contact frequency. Day services level of need will only determine visit frequency if the person receives no residential services. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ISPPCSP for that person per service received across service settings. Face-to-face visits should be coordinated with the person supported (and their family, as applicable) and should generally occur in the person's residence at least once per quarter. 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. When an individual receives residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request or based on a significant change in needs or circumstances. The frequency of monitoring visits may be provided more frequently as needed. Information is gathered using standardized processes and tools.~~

Commented [EI14]: DIDD CM for SD Waiver

~~The ISC may, if preferred by the person and/or legal guardian, if applicable, and documented in the PCSP, complete some of the minimally required visits using telehealth specifically online videoconferencing using a tablet or other smart mobile device. If virtual technology is not available to the person, then a telephone contact may be acceptable to allow flexibility per the family's request.~~

~~All of the following, at a minimum, shall require in-person face-to-face visits, absent extenuating circumstances such when an in-person meeting may negatively impact the person or coordinator's health or safety:~~

~~Annual re-assessment or planning meeting for purposes of updating the PCSP;~~

~~Quarterly visits for persons assessed to have level of need 1, 2, or 3 for purposes of reimbursement of residential services (Supported Living, Residential Habilitation, and Family Model Residential), and persons not receiving any residential or day service reimbursed based on level of need;~~

~~Bi-monthly visits for persons assessed to have level of need 4 for purposes of reimbursement of residential services (Supported Living, Residential Habilitation, and Family Model Residential);~~

~~Monthly visits for persons assessed to have level of need 5 or 6 for purposes of reimbursement of residential services (Medical Residential Services, Supported Living and Residential Habilitation); and~~

~~When there is a significant change in condition defined as:~~

~~a. Change in community placement to a residential setting (i.e. Supported Living, Medical Residential) or a change between residential settings;~~

~~b.Loss or change in primary caregiver or loss of essential social supports for a person not receiving residential services;~~

~~c. Significant change in physical or behavioral health and/or functional status, including but not limited to hospital (acute or psychiatric) admission for purposes of ensuring appropriate supports are available upon discharge; following any hospital discharge (to ensure the person's needs are being met, ensure continuity of care, and avoid potential readmission; following any out-of-home placement related to behavior support needs;~~

~~d.Repeated instances of reportable events; or~~

~~e.Any other event that significantly increases the perceived risk to a person.~~

Appendix D: Participant Services

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

A uniform risk assessment is administered as part of the process for developing the person's ~~ISP~~PCSP. A person-centered approach is employed to identify risk factors and develop proactive strategies to address those factors. The tool identifies potential situational, environmental, behavioral, medical, and financial risks. When risks are identified, the strategies necessary to address them are incorporated into the ~~ISP~~PCSP.

As part of the PCSP, each person supported receiving services in their own home (i.e., non-residential services) will have a back-up plan which specifies unpaid persons as well as paid consumer-directed workers and/or

contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled HCBS providers or workers are unavailable or do not arrive as scheduled.

Appendix D: Participant Services

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

~~Participation in a waiver program is voluntary. Prior to being enrolled in or transferred to a the CAC waiver, a qualified applicant has the right to freely choose whether they want to receive services in the waiver or in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).~~ Beginning ~~July 1, 2021~~ January 1, 2023, waiver services will be delivered through managed care under concurrent 1115 waiver authority via an amendment to the TennCare III demonstration. Continuity of services and providers selected by each waiver participant will be assured through a requirement that MCOs contract with all currently contract 1915(c) waiver providers for at least the first year. Thereafter, waiver participants will be permitted to continue to ~~Freedom of choice also includes the right to~~ select any provider with an active provider agreement with the ~~Department of Intellectual and Developmental Disabilities (DIDD) and the Division of TennCare~~ MCO if the provider is available, willing, and able ~~to provide the services needed. , and choice of the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.~~

~~The state ensures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written ISPPCSP.~~ The ISC will provide information about selecting from among qualified contracted providers of the waiver services in the ~~ISP~~PCSP.

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Independent Support Coordinators (ISC) assist persons supported in identifying needs and preferences, and in selecting, obtaining, and coordinating services using paid and natural supports. Ongoing monitoring by ISCs is essential and they are responsible for determining if services are being implemented as specified in the ~~ISP~~PCSP and if the services described in the plan are meeting the person's needs.

Ongoing monitoring by ISCs is accomplished through a stratified approach, based on level of support need, as follows: 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 ~~a minimum of~~ at least one ~~monthly~~ in-person or telephone contact per calendar month with an in-person contact occurring at least every other month. At least once every three months, for level of need 1, 2, or 3 residential services (Supported Living, Residential Habilitation, and Family Model Residential), a visit must occur in the person's home; and 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. ~~and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home.~~ 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 ~~a minimum of~~ at least one ~~monthly~~ face-to-face contact per calendar month across all environments ~~and in the person's residence at least quarterly~~. 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. At least once every three months, for level of need 4, 5, or 6 residential services (Supported Living, Residential Habilitation, Medical Residential, and Family Model Residential), a visit must occur in the person's home; or 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. ~~Residential level of reimbursement is the overriding determinant of the contact frequency. Day services level of need will only determine visit frequency if the person receives no residential services.~~ The level of need for reimbursement of residential services is the overriding determinant of the type and frequency of contacts. The level of need or employment and day services will determine type and frequency of contacts only if the person receives no residential services. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ~~ISP~~PCSP for that person per service received across service settings. In addition to general assurance of health and safety, the purpose of this review shall be to ensure that services and supports are being provided in accordance with the PCSP and are appropriate to support the achievement of individualized goals and outcomes. Progress toward goals and outcomes shall be reported as part of the Monthly Status Review. ~~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.~~

The ISC may, if preferred by the person and/or legal guardian, if applicable, and documented in the PCSP, complete *some* of the minimally required visits using telehealth-specifically online videoconferencing using a tablet or other smart mobile device. If virtual technology is not available to the person, then a

Commented [EI15]: Everywhere this says ISC would be DIDD CM in the SD Waiver

telephone contact may be acceptable to allow flexibility per the family's request.

All of the following, at a minimum, shall require in-person face-to-face visits, absent extenuating circumstances such when an in-person meeting may negatively impact the person or coordinator's health or safety:

(1) Annual re-assessment or planning meeting for purposes of updating the PCSP;

~~(2) Quarterly visits for persons assessed to have level of need 1, 2, or 3 for purposes of reimbursement of residential services (Supported Living, Residential Habilitation, and Family Model Residential), and persons not receiving any residential or day service reimbursed based on level of need;~~

~~(3) Bi-monthly visits for persons assessed to have level of need 4 for purposes of reimbursement of residential services (Supported Living, Residential Habilitation, and Family Model Residential);~~

~~(4) Monthly visits for persons assessed to have level of need 5 or 6 for purposes of reimbursement of residential services (Medical Residential Services, Supported Living and Residential Habilitation); and~~

(2) When there is a significant change in condition defined as:

a. Change in community placement to a residential setting (i.e. Supported Living, Medical Residential) or a change between residential settings;

b. Loss or change in primary caregiver or loss of essential social supports for a person not receiving residential services;

c. Significant change in physical or behavioral health and/or functional status, including but not limited to hospital (acute or psychiatric) admission for purposes of ensuring appropriate supports are available upon discharge; following any hospital discharge (to ensure the person's needs are being met, ensure continuity of care, and avoid potential readmission; following any out-of-home placement related to behavior support needs;

d. Repeated instances of reportable events; or

e. Any other event that significantly increases the perceived risk to a person.; and

(3) At any time based on the member's preference for in-person meetings.

In addition, the ISC conducts initial (i.e., as part of the State's initial assessment of compliance with the new federal HCBS Setting rule) and at least annual assessment of the individual's experience, in accordance with timeframes outlined in State Protocol, to confirm that that the setting in which the person supported is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the ~~person-centered ISP~~PCSP.

Appendix D: Participant-Centered Planning and Service Delivery Quality Improvement: Service Plan

The State is revising the sampling methodology for the following performance measure:

a.i.a.4. # and % of consumer satisfaction survey respondents who reported that the things important to them were addressed in their Person-Centered Support Plan. (People Talking to People Consumer survey question: "Were the things that are important to you included in your PCSP?") % = # of respondents reporting that important things were addressed in the PCSP / total # of respondents.

Sampling Approach *(check each that applies):*
☐ 100% Review
☑ Less than 100% Review
☐ ~~☑~~ Representative Sample Confidence Interval: ~~+/- 5%~~
☑ ☐ Stratified Describe Group: subgroups among the three grand regions in Tennessee (West, Middle, and East)
☐ Other

The State is adding the following new performance measure:

Data Source (Select one):

Other

If 'Other' is selected, specify:

DIDD Participant Satisfaction Survey

a.i.a.5. Number and percentage of consumer satisfaction survey respondents who reported that their needs were addressed in their Person-Centered Support Plan (People Talking to People Consumer survey question: "Does your PSCP meet your needs?") % = # of respondents reporting that PCSP meets their needs / total # of respondents.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☑ Monthly	☑ Less than 100% Review
☐ Other Specify:	☐ Quarterly	☐ Representative Sample Confidence Interval:
	☐ Annually	☑ Stratified Describe Group: subgroups among the three grand regions in Tennessee (West, Middle, and East)
	☐ Continuously and Ongoing	☐ Other
	☐ Other Specify:	

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Performance Measures a.i.b.2. and a.i.b.3., a.i.c.1 and a.i.c.2, a.i.d.2 through a.i.d.5, ~~and a.i.e.1,~~ a.i.e.4, and a.i.e.5: A representative sample of waiver participants (persons supported) will be generated at the ~~beginning~~ end of the waiver year.

Performance measure a.i.a.4: Data will be generated by contracted interviewers who complete DIDD People Talking to People Consumer Satisfaction Surveys. Interviewers are trained prior to conducting surveys regarding policies and procedures for identifying and reporting complaints and allegations of abuse, neglect, and exploitation.

Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Performance Measures a.i.a.2, a.i.b.2. and a.i.b.3., a.i.c.1, ~~and~~ a.i.c.2, a.id.2 through a.i.d.5, ~~and~~ a.i.e.4~~1~~, and a.i.e.5~~2~~: Designated DIDD Regional Office staff will notify Support Coordination (ISC) Agencies and other provider agencies as appropriate when service planning and implementation compliance issues are identified. Performance Measure a.i.a.4 and ~~a.i.d.5~~ a.i.a.5: When individuals report issues with the PCSP, the satisfaction survey (known as People Talking to People Survey) interviewer will notify the DIDD People Talking to People Director within three business days.

Commented [EI16]: DIDD CMs for SD waiver

III. Adding consumer direction options for Statewide and CAC Waivers

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*: View Section

X Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) This waiver provides an opportunity for participant direction, referred to in this waiver and concurrent 1115 waiver authority as "Consumer Direction." This means that a waiver participant may elect to direct and manage (or to have a Representative direct and manage) certain aspects of the provision of specified services that are available for consumer direction--primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the service(s), and the delivery of each service within the authorized budget for that service. Services that may be consumer directed in this waiver include only:

1. Respite Services;
2. Personal Assistance; and
3. Individual Transportation Services.

(b) Waiver participants assessed to need one or more of these services are informed of the opportunity to participate in consumer direction as part of educational materials developed by TennCare and discussed with the person by the ISC. The person supported or the conservator will decide whether to directly manage these services or receive them from a contracted qualified provider. A person supported who does not have a legally appointed representative may designate one or more individuals (including family members, friends, or other persons) to serve as a representative for consumer direction. Requirements that the representative must meet are set forth in State Administrative Rule. When a representative for consumer-direction has been designated, the person supported will participate in consumer- direction activities to the extent they are able and allowed under the legal representation. A person may elect to participate or withdraw from participation in consumer direction at any time.

If a person elects consumer direction for one or more services, the PCSP will identify the services that the person supported has elected to manage directly. The responsibilities of the person supported (or his/her representative for consumer direction) which include all aspects of serving as an employer of record are set forth in TennCare Administrative Rule, a Consumer Direction handbook, TennCare contracts with the MCO and FMS/Supports Brokerage entity, and TennCare policy or protocol.

(c) When a person supported or the conservator or family elects to manage one or more services included in the PCSP, they will be supported by TennCare's contracted Financial Management/Supports Brokerage entity and their ISC as follows:

1. Financial Management

The state contracts with a Financial Management Services (FMS) provider contracted as a Section 3504 Agent in accordance with Internal Revenue Code for participant managed programs. A person supported must utilize the TennCare contracted FMS entity when consumer direction is elected. The FMS is responsible for acting on behalf of the employer of record (EOR) in regards to managing payroll and tax filing and recording activities, including:

- Providing the person supported or the guardian/conservator of the person supported with the information and materials required for them to carry out consumer direction
- Preparing and submitting a monthly budget status report to the person supported and the ISC; and

Commented [EI17]: Changes are applicable to Statewide and CAC waivers. The language in the SD Waiver remains unchanged.

- Verification that providers of services managed by the person supported possess the qualifications specified in state regulations and arranging for the criminal background checks at no cost to the person supported.

2. Supports brokerage is an activity provided by the FMS/Supports Brokerage entity which provides training to the person supported concerning self-direction and assists the person supported as needed or requested with certain activities associated with their role as an EOR. The types of assistance available are set forth in TennCare Administrative Rule, a Consumer Direction handbook, TennCare contracts with the MCO and FMS/Supports Brokerage entity, and TennCare policy or protocol.

:

3. Independent Support Coordinator (ISC) Role in Self-Direction The ISC will:

- Provide an orientation to consumer direction so that the person supported has the information necessary to understand the requirements and responsibilities associated with consumer direction;
- Inform persons supported who elect consumer direction of the required use of the TennCare contracted FMS/Supports Brokerage entity;
- Continuously review the status of the approved budget for each service and assist the EOR in managing the budget, as needed and requested;
- Conduct ongoing monitoring of the implementation of the PCSP and health and welfare of the person supported, including as it relates to participate in consumer direction; and
- Support the EOR in activating the back-up plan when needed.

~~a.~~

Appendix E: Participant Direction of Services E-1: Overview (2 of 13)
b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*: ~~c.~~ The State will select Both Employer and Budget Authority. The budget for each service will be established in accordance with TennCare policy.
~~d.~~c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*: Consumer direction will be available only to participants who live in their own private residence or the home of a family member. Only the following services may be consumer directed: personal assistance, respite, and individual transportation services.
Appendix E: Participant Direction of Services E-1: Overview (3 of 13)
e.d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

O The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria: Services that may be consumer directed are limited to personal assistance, respite and individual transportation services. Only individuals receiving these services are eligible to participate. Individuals receiving residential services are not eligible for consumer direction. Individuals participating in consumer direction must use the services of TennCare's contracted Financial Management Services/Supports Brokerage entity, and comply with all applicable State Rules and policies pertaining to Consumer Direction.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

~~f.~~e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Waiver participants assessed to need one or more of these services are informed of the opportunity to participate in consumer direction as part of educational materials developed by TennCare and discussed with the person by the ISC during the annual person-centered planning meeting. The educational materials describe the benefits and potential risks of consumer direction, the person (or representative)'s responsibilities, and the supports that will be available if consumer direction is elected. If consumer direction is elected, additional detail is provided by the Supports Broker as part of EOR training, including a Consumer Direction handbook.

~~g.~~

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

~~h.~~f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

O The State does not provide for the direction of waiver services by a representative.

X The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies):*

☑ ~~☐~~ **Waiver services may be directed by a legal representative of the participant.**

☑ Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A person may designate, or have appointed by a legal guardian or conservator, a representative to assume the consumer direction responsibilities on his/her behalf. A representative shall meet, at minimum the following requirements: be at least 18 years of age, have a personal relationship with the person and understand his/her support needs; knows the person's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the person's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each worker.

The ISC will verify that a representative meets these qualifications.

A person's representative for consumer direction cannot receive payment for serving in this capacity and shall not serve as the person's worker for any consumer directed service.

The representative must sign a representative agreement with the person (or his/her legal representative) developed by TennCare to confirm the requirements are met, the individual's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein.

ISCs will monitor on an ongoing basis to ensure that the person's needs are being met through consumer direction and are responsible for reporting any concerns to DIDD.

If the representative of the person supported is unwilling or unable to carry out the responsibilities outlined above, or refuses to abide by the PCSP or waiver policies, DIDD may require the person supported to select another personal representative.

A person may also be involuntarily disenrolled from participation in Consumer Direction when necessary to ensure the person's health and safety (subject to due process rights). In that case, the person will receive services through a contracted qualified provider.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

~~i.~~g. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

X Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*.

☐ Governmental entities

☐ Private entities

O No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

~~j.~~h. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

O FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

X FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The State provides Financial Administration Services as an administrative activity through TennCare's contract with a FMS entity. The contract was awarded through the State's competitive procurement process.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS entity is reimbursed by TennCare for administrative activities performed under the contract. This includes a per person per month fee for Financial Management and Supports Brokerage assistance, a one-time set-up fee for each person supported (the EOR), and a one-time set-up fee for each worker (employee).

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☐ Assist participant in verifying support worker citizenship status

☐ Collect and process timesheets of support workers

☒ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

☒ Other

Specify:

-Verifying that services for which payment is requested have been authorized in the PCSP;
-Ensuring that requests for payment have been approved by the person supported or the representative for consumer direction.

-Filing claims for waiver services provided through consumer direction;

Supports furnished when the participant exercises budget authority:

☒ Maintain a separate account for each participant's participant-directed budget

☒ Track and report participant funds, disbursements and the balance of participant funds

☒ Process and pay invoices for goods and services approved in the service plan

☒ Provide participant with periodic reports of expenditures and the status of the participant-directed budget

☐ Other services and supports

Specify:

Additional functions/activities:

☐ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

☒ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

☐ Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget

☐ Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

TennCare monitors the performance of the FMS on an ongoing basis through required reports and program discussions. Prompt remediation of all issues and concerns is required, with remedies provided through the contract, as needed. In addition, on an annual basis, TennCare and/or the Department of Intellectual and Developmental Disabilities (DIDD) conducts a performance audit of the FMS contractor. The auditors review a sample of persons supported for whom the contractor provides financial management services. If deficiencies are identified during the audits, the contractor will be required to submit an acceptable corrective action plan that addresses the deficiencies.
DIDD reports findings of its audits to TennCare via monthly Quality Monitoring Reports.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

~~k.i.~~Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

All participants will have an assigned ISC. The ISC will have the following responsibilities as they relate to Self-Direction:

- Facilitate the development of the PCSP, including arranging for a person-centered planning facilitator if desired by the person supported and providing necessary information and support to the person supported to ensure that the person supported directs the PCSP process to the maximum extent desired and possible;
- Prevent the provision of unnecessary or inappropriate services and supports;
- Ensure that the PCSP is developed pursuant to the person-centered planning rules, including the following:
  - The plan reflects cultural considerations and uses plain language;
  - The plan development process includes strategies for solving conflict/disagreements, as applicable;
  - The process is timely and occurs at convenient time/location for person supported;
  - The process provides method for the person supported to request updates to the PCSP.
- Ensure that services are initiated within required time frames;
- Provide an orientation to self-direction so that the person supported has the information necessary to understand the requirements and responsibilities associated with self-direction;
- Inform persons supported who elect self-direction of the required use of the TennCare contracted Financial Management/Supports Brokerage entity;
- Continuously review the status of the budget;
  - ~~1.~~Facilitate an employment informed choice process with the expectation of exploring employment and supporting the person to make informed choices about work and other integrated service options, clearly prioritizing employment and community integration over home-based or facility-based supports;
  - ~~2.~~Conduct an assessment which identifies how Enabling Technology supports an individual's increased independence in their home, community, and workplace;
- Conduct ongoing monitoring of the implementation of the PCSP and health and welfare of the person supported, including review/revision upon reassessment of functional need at least every 12 months, when the circumstances or needs of the person supported change significantly, or at the request of the person supported; and,
- Arrange alternative emergency back-up services as necessary in the event that the emergency back-up services provided for in the PCSP cannot be employed.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

10. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where

required, provide the additional information requested *(check each that applies)*: ☑ Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

~~10.~~ Support Coordination

☑ Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

(a) TennCare contracts with a financial management services/supports brokerage entity to provide assistance to persons electing consumer direction or to their representative for consumer direction.
(b) The contract is awarded through the State's competitive procurement process.

The FMS entity is reimbursed by TennCare for administrative activities performed under the contract. This includes a per person per month fee for Financial Management and Supports Brokerage assistance, a one-time set-up fee for each person supported (the EOR), and a one-time set-up fee for each worker (employee).

~~(a)~~(c) Among many FMS and supports brokerage activities, this entity is responsible for providing the person supported or their guardian/conservator with the information and materials necessary to self-direct services, including procedures for approving payment for services and obtaining necessary payroll and employment information. This information is provided through a consumer direction handbook and through training provided to the person and/or representative by the Supports Broker.

~~(b)~~(d) and (e) TennCare monitors the performance of the FMS on an ongoing basis through required reports and program discussions. Prompt remediation of all issues and concerns is required, with remedies provided through the contract, as needed. In addition, on an annual basis, TennCare and/or the Department of Intellectual and Developmental Disabilities (DIDD) conducts a performance audit of the FMS contractor. The auditors review a sample of persons supported for whom the contractor provides financial management services. If deficiencies are identified during the audits, the contractor will be required to submit an acceptable corrective action plan that addresses the deficiencies. DIDD reports findings of its audits to TennCare via monthly Quality Monitoring Reports.

Appendix E: Participant Direction of Services
E-1: Overview (10 of 13)
~~i~~j. Independent Advocacy *(select one)*.
X No. Arrangements have not been made for independent
Appendix E: Participant Direction of Services
E-1: Overview (11 of 13)

Commented [EI18]: Note that individuals participating in consumer direction may receive assistance through TennCare's contracted Beneficiary Supports System.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

An individual who has elected to participate in consumer direction and continues to be eligible for the waiver program may voluntarily elect to terminate participation in consumer direction as the method of service provision and receive waiver services through a contracted qualified provider. To voluntarily terminate participation in consumer direction of one or more services, the person must contact the ISC. The ISC will assist the person in updating the PCSP and in selecting a contracted qualified provider for each applicable service that is available and willing to provide services timely. The ISC will coordinate with DIDD and with the provider to facilitate a seamless transition from services delivered through consumer direction to services from the provider agency, and will continue to monitor throughout the transition to ensure the person's needs are met.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An individual who has elected consumer direction and continues to be eligible for the waiver program may be involuntarily required to terminate participation in consumer direction as the method of service provision and receive waiver services through a contracted qualified provider under the following circumstances:

1.The person is no longer willing or able to serve as the employer of record for his or her employees and to fulfill all of the required responsibilities for consumer direction, and does not have a qualified representative who is willing and able to serve as the employer of record and to fulfill all of the required responsibilities for consumer direction.

2.The person is unwilling to participate in identifying and addressing risks any additional risks associated with the person's decision to participate in consumer direction, or the risks associated with the person's decision to participate in consumer direction pose too great a threat to the person's health, safety, and welfare.

3.The person's health, safety, and welfare are in jeopardy if the person or his or her representative continues to employ a worker, but the person or representative does not want to terminate the worker.

4. The person refuses to develop a backup and emergency plan for consumer directed workers

5.The person or his or her representative for consumer direction or consumer directed workers he or she wants to employ are unwilling to use the services of the department's contracted FMS/SB to perform required financial management services and supports brokerage functions.

6.The person or his or her representative is unwilling to abide by the requirements of the waiver program specific to consumer direction.

7.If a person's representative fails to perform in accordance with the terms of the representative agreement and the health, safety, and welfare of the person is at risk, and the person wants to continue to use the representative.

8.If the person has consistently demonstrated that he or she is unable to manage, with sufficient supports, including appointment of a representative, his or her services and the ISC or FA/SB has identified health, safety, and or welfare issues.

9.Other significant concerns identified and reported and or documented by the person's supports broker, ISC or member of the Circle of Support regarding the person's participation in consumer direction which jeopardize the health, safety or welfare of the person.

In the event that consumer direction option is involuntarily terminated, the person's ISC will work with the person supported to revise the PCSP. Termination of participation in consumer direction option will not affect the ongoing receipt of services specified in the PCSP. The ISC will assist the person in updating the PCSP and in selecting a contracted qualified provider for each applicable service that is available and willing to provide services timely. The ISC will coordinate with DIDD and with the provider to facilitate a seamless transition from services delivered through consumer direction to services from the provider agency, and will continue to monitor throughout the transition to ensure the person's needs are met.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

~~m.k.~~Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		
Year 2		
Year 3		
Year 4		
Year 5		

YEAR	YEAR	CAC	SW	TOTAL
4	2023	4	45	49
5	2024	3	40	43
TOTAL		7	85	92

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☐ Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☐ Recruit staff

☐ Hire staff common law employer

☐ Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

☐ Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

☐ Determine staff wages and benefits subject to State limits

☐ Schedule staff

☐ Orient and instruct staff in duties

☐ Supervise staff

☐ Evaluate staff performance

☐ Verify time worked by staff and approve time sheets

☐ Discharge staff (common law employer)

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ Determine the amount paid for services within the State's established limits
- ☐ Schedule the provision of services
- ☐ Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- ☐ Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Waiver participants shall have modified budget authority. Once a budget has been established based on the person's needs and the units of service necessary to meet the person's needs, the budget for personal assistance and a separate budget for individual transportation services shall be allocated on a monthly basis and the budget for respite services shall be allocated on an annual basis. For persons electing to receive the ~~hourly~~ respite benefit (up to ~~two hundred sixteen (216) hours~~ thirty (30) days per year), the annual respite budget will be a dollar amount. The member may direct each service budget available through Consumer Direction so long as the applicable budget is not exceeded. This information will be provided to waiver participants participating in consumer direction as part of the consumer direction handbook, and is also set forth publicly in TennCare Administrative Rules.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

A budget for each service the person elects to receive through consumer direction is established as part of the person-centered planning process based on the person's needs and the units of service necessary to meet the person's needs. This information is part of the PCSP; the person participates in developing the PCSP, signs the PCSP, and receives a copy. Any adjustments to the approved budget for each service elected through Consumer Direction may also be requested through the person-centered planning process, subject to applicable limits on each service and other program requirements.

During the PCSP development process, all persons supported and families will receive an orientation to consumer direction. Persons supported who express an interest in consumer direction will be provided more in-depth information, including a Consumer Direction handbook. This information will include information about modifying the budget. Requests for adjustments in the budget amount or in waiver services are submitted through the ISC. The State provides notice, including the right to request a fair hearing, regarding any adverse action pertaining to the denial of a waiver service, including requested increases in the budget of a service provided through consumer direction.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

X Modifications to the participant directed budget must be preceded by a change in the service plan.

O The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Independent Support Coordinators assist persons supported in identifying their needs and preferences, and selecting, obtaining and coordinating services. Persons enrolled in this waiver shall be contacted by their ISC as indicated within the Support Coordination service definition in Appendix C of this waiver. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the member's needs or based on a significant change in needs or circumstances.

For persons supported who consumer direct services, the Financial Management entity prepares and submits monthly budget status reports to the person supported and to the ISC. In addition, the Financial Management entity is required to alert the person supported or representative, as appropriate, and the ISC whenever the pattern of expenditures reveals the potential that the budget would be prematurely exhausted. The ISC will review the monthly expenditure report with the person supported or representative, as appropriate, to identify and discuss potential problems, including potential over-expenditure of funds or expenditure patterns that might indicate that the person supported is having difficulty in accessing authorized services. The ISC will assist the participant as needed to ensure the PCSP is adequate to meet the person's needs and the person supported or representative is properly trained on how to manage the budget.

Because the budget for personal assistance and individual transportation services are allocated on a monthly basis, the likelihood of these challenges is reduced.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Medicaid Agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the ~~provider(s),~~ services and settings of their choice.

As part of the managed care program, individuals with 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.

PROCESS:

The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E:

1. A plain language explanation of appeal rights ~~shall~~ is ~~be~~ provided to persons supported upon enrollment in the waiver and on an ongoing basis as part of the Member Handbook, and as part of any notice of adverse action.

2. TennCare's contractor (DIDD or the MCO) shall provide in advance a plain language written notice to the persons supported of any action to delay, deny, terminate, suspend, or reduce waiver services, including the setting in which services ~~and~~ are provided~~, or of any action to deny choice of available qualified providers~~.

Clarifications to the Grievance and Complaint process in Appendix F

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A waiver participant may file a grievance or complaint regarding any concern pertaining to the quality or satisfaction with waiver services provided.

A grievance or complaint may be submitted to the provider, DIDD, or TennCare.

Contracted waiver providers are required to establish a complaint resolution system, notify each person supported and or their legal representative of their Complaint Resolution System and how to access it. This information shall identify both the provider and DIDD contact persons and their contact information.

Providers are expected to resolve all complaints in a timely manner, and within 30 calendar days of the date that the complaint was filed.

If a resolution cannot be achieved between the provider and the complainant or if the resolution is not satisfactory, a formal complaint may be filed with the DIDD Customer-Focused Services Unit.

DIDD Complaint Resolution System

DIDD utilizes staff from their Customer Focused Services Unit to receive complaints and work with waiver participants and their families, as well as contracted providers, and the MCO, when appropriate, to determine the appropriate actions needed to resolve complaints and ensure that actions are implemented in a timely manner (within a 30 calendar day targeted timeframe). The DIDD CFS Unit has trained Rule 31 Mediators.

~~If a resolution cannot be achieved between the provider and the complainant, a formal complaint shall be filed with the DIDD Customer-Focused Services Unit. In the event that persons supported, family members and/or legal representatives do not agree with a provider's proposed solution to a complaint, they may contact the DIDD Regional Complaint Resolution Coordinator for assistance.~~ The DIDD Regional ~~Complaint Resolution~~ Customer-Focused Services (CFS) Coordinator will:

- Contact the complainant within two (2) business days of receiving the complaint (via phone, email, etc.).
- Collect information from the complainant, including whether attempts to resolve issues and concerns have been made with the subject of the complaint.
- Complete a record of the complaint in the appropriate system for monitoring and tracking complaints.
- Contact provider and other relevant parties, objectively gathering information relevant to the complaint.
- Upon gathering of information, determine what actions will best meet the party's needs for bringing resolution to the complaint.
- Obtain the provider's plan of action and identify a target date for resolution, confirmed via a written email notification to the CFS Coordinator involved.
- Obtain from the provider confirmation by the target date via mail, fax or email that the agreed upon actions have been completed such that resolution has been achieved.
- Complaints filed in the established tracking/monitoring system shall be resolved no later than thirty (30) calendar days from receipt of the complaint. Additional time may be allotted on a case by case basis.
- CFS Coordinator will notify the complainant of the outcome of the formal complaint within five (5) business days.
- Regional CFS Coordinators shall notify and ask for assistance from the CFS State Director if the complaint has not been satisfactorily resolved.
- If a complaint cannot be resolved via the Complaint Resolution and/or Conflict Resolution a request for formal mediation shall occur by contacting the certified Rule 31 Mediator located in the CFS Unit, or elsewhere.

- ~~Contact the provider(s) and/or other party(ies) involved to discuss potential resolutions to the complaint. These could include formal mediation or intervention meetings~~.
- ~~Resolve the complaint within 30 calendar days of the date that the complaint was filed~~.
- ~~Notify, in writing, the provider(s) and/or other party(ies) involved of the outcome of the complaint within 2 business days of resolution~~.

In the event the person filing the complaint is not satisfied with the outcome or if a complaint is filed directly with TennCare, the complaint will be referred to the LTSS ~~Quality and Administration~~ Director of ID~~/DD~~ Services or designee. A complaint is any allegation or charge against a party, an expression of discontent, or information as it pertains to ~~wrong doing~~ wrongdoing affecting the well-being of a person supported.

If the complainant indicates that DIDD has been notified of the complaint/problem and has not responded timely or satisfactorily, TennCare staff will contact the appropriate DIDD staff ~~by telephone~~ within two (2) business days ~~(unless requested not to do so by the complainant)~~ to advise of the nature of the complaint and request that all information pertaining to the complaint be provided within five (5) business days, including any actions taken to resolve the complaint or problem as of the date of the contact.

A ~~follow-up memo~~ Request for Information (RFI) will be sent to DIDD ~~via fax or mail~~ to document the date of DIDD notification, the request for related DIDD information, and the expected date of receipt.

~~DIDD~~ The LTSS Director of ID Services or designee will be required to collect any requested information from involved providers ~~and submit it to the TennCare Division of Long Term Services and Supports~~.

Upon receipt of information regarding DIDD and/or provider completed actions or anticipated actions, a determination will be made as to whether adequate steps have been or are being taken to resolve the issue.

Sufficient follow-up contacts to the complainant and DIDD will be made by TennCare LTSS ~~Quality and Administration~~ staff to determine if the problem has been adequately resolved. Outstanding complaint cases will be discussed at ~~the monthly~~ TennCare/DIDD meetings, as necessary.

The complainant will receive written notification from designated TennCare, including the date~~a~~ the complaint was considered resolved and closed, a summary of information discovered, and remedial actions taken.

~~DIDD Complaint Resolution System~~

~~DIDD utilizes staff from their Customer Focused Services Unit to receive complaints and work with waiver participants and their families, as well as contracted providers, to determine the appropriate actions needed to resolve complaints and ensure that actions are implemented in a timely manner (within a 30 calendar day targeted timeframe). The DIDD CFS Unit has trained Rule 31 Mediators.Complaint coordination staff receive training in mediation techniques.~~

~~DIDD service providers are required to establish a complaint resolution system and inform persons supported and or their legal representative of this system and allow easy access when seeking assistance and answers for concerns and questions about the care being provided. Upon admission and periodically, DIDD service providers are required to notify each person supported and or their legal representative of their Complaint Resolution System, its purpose and the steps involved to access it. This information shall identify both the provider and DIDD contact persons and their contact information.~~

~~Providers are asked to resolve all complaints in a timely manner, and within 30 calendar days of the date that the complaint was filed. If a resolution cannot be achieved between the provider and the complainant, a formal complaint shall be filed with the DIDD Customer Focused Services Unit. In the event that a person supported and or their legal representative does not agree with a provider's proposed resolution to a complaint, they may contact the DIDD Complaint Resolution Unit for assistance. The DIDD Regional Complaint Resolution Customer Focused Services Coordinator will subsequently contact~~

~~the provider(s) and or other party(ies) involved to discuss potential resolutions to the complaint. This could include formal mediation or intervention meetings. Additionally, independent support coordinators/case managers are required to notify individuals of their rights, including how to file a complaint, an explanation of their appeal rights and the process for requesting a fair hearing, upon enrollment into a waiver program.~~

Information collected is compiled and reported to TennCare in the monthly Quality Management Report, and data files, which are available to TennCare upon request, are also completed by DIDD ~~Complaint Resolution~~ Customer-Focused Services Staff for each complaint with data detailing the number and type of complaints received, referral sources, remedial actions, and timeframes for achieving resolution.

- Changes in Appendix G to align critical incident management terms, definitions, and processes across HCBS programs

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Intellectual and Developmental Disabilities (DIDD) requires reporting of all ~~incidents~~ events classified as "Reportable. This applies to employees and volunteers of contracted service providers, as well as DIDD employees who witness or discover such an ~~incident~~event.

~~Critical events~~Reportable Events categorized as Tier 1 allegations of abuse, neglect, exploitation, suspicious injury, serious injury of unknown cause and unexpected/unexplained deaths are required to be reported to the DIDD ~~Investigations~~ Abuse hotline within four (4) hours of the discovery of the ~~incident~~event. ~~The incident can be reported by telephone, email, and fax or in person~~. Within one (1) business day, the ~~incident~~ event is reported ~~by email or fax~~ to DIDD Central Office and the ISC Agency/Support Coordinator using a Reportable ~~Incident~~ Event Form (REF). For all other ~~incidents~~ events that are not reported as ~~abuse, neglect, exploitation, suspicious injury, serious injury of unknown cause or unexpected or unexplained death,~~ Tier 1, a next business day reporting requirement is in place. Those incidents events are reported to DIDD Central Office via the ~~Reportable Incident Form~~REF ~~by email or fax~~. The hotline number and ~~Reportable Incident Form~~ REF are located on the DIDD Website.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The DIDD ~~Protection From Harm~~ Reportable Event Management Unit receives Tier 1 allegations of abuse, neglect, exploitation, serious injuries of unknown cause and suspicious deaths. All such ~~incidents~~ events are investigated by trained DIDD investigators who interview the participant, service provider, and all available witnesses. The DIDD investigators examine the ~~incident~~ event scene and collect other available relevant circumstantial evidence (written statements, expert medical opinions as needed, etc.). Based on ~~the~~ clear and convincing ~~preponderance of the cited~~ evidence, each allegation is determined to either be substantiated or unsubstantiated, and a formal written Investigation Report is generally completed within 30 calendar days of the allegation being witnessed or discovered. (In some extraordinary situations, such as a pending criminal investigation, the DIDD investigation may take longer than 30 calendar days. DIDD requires the waiver service provider to develop and implement a written ~~management~~ action plan that addresses the issues and conclusions specified in the DIDD Investigations report within 10~~4~~ calendar days of the completion of the Investigation Report.

For all other "Reportable ~~Incidents~~Events", DIDD requires the person witnessing or discovering the ~~incident~~ event to ensure that a written ~~incident report~~Reportable Event Form (REF) ~~form~~ is forwarded to the responsible waiver service provider and to DIDD. The service provider is required by DIDD to have ~~incident~~ reportable event management processes and personnel in place sufficient to review and respond to all "Reportable ~~Incidents~~Events". The service provider is required to ensure that the ~~incident~~ reportable event and the initial response to the ~~incident~~ event are documented on the ~~incident report form~~REF, to review all provider ~~incidents~~ reportable events ~~are~~ reviewed ~~immediately~~ and discussed during ~~biweekly~~ monthly provider reportable event review meetings for the purpose of identifying any additional actions needed, and to organize all ~~incident~~ reportable event information in a way that would facilitate the identification of at-risk participants as well as other trends and patterns that could be used in agency-level ~~incident~~ reportable event prevention initiatives.

For Tier 1 Investigations, t~~T~~he relevant parties ~~of an investigation~~ are notified of the results ~~of an investigation~~ via the following:

1. ~~1.~~The DIDD Summary of Investigation Report will be sent to the support coordination provider/DIDD case manager for all persons supported involved in the ~~incident~~event.

Service providers are responsible for conducting investigations of Tier 2 Reportable Events and submitting an investigation report to DIDD for each Tier 2 allegation. A completed investigation report and attachments shall be submitted to DIDD within twenty-five (25) calendar days of the date the provider receives notification of the investigation assignment/opening.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Intellectual and Developmental Disabilities (DIDD) is the agency responsible for overseeing the reporting of and response to all "Reportable ~~Incidents~~Events".

All "Reportable ~~Incidents~~Events" received by DIDD are reviewed for completeness of information (with follow-up for more information if needed), are categorized according to written criteria, and are entered into an electronic database. This database provides data management capabilities including the ability to:

1. Generate "alerts" of individual incidents events to designated DIDD staff for follow-up as needed;
2. Support reporting to external entities (e.g., TennCare); and
3. Support internal DIDD trends analysis and reporting functions such as:
a. Identification of at-risk participants;
b. Identification of employees or contract staff with multiple episodes of substantiated abuse, neglect, and exploitation allowing voluntary screening of prospective employees by service providers during the hiring process;
c. Identification of at-risk situations (e.g., data on injuries from falls);
d. Creating a detailed profile of identified service providers, with information about reportable incidents events related to that provider, and for comparison between service providers; and
e. Distribution of monthly reports to DIDD management and other staff.

All Incident Reportable Event and Investigation reports completed by DIDD are available for TennCare review. Monthly data files and Quality Management Reports are submitted to TennCare containing information about the number and types of critical incidents reportable events reported, the number of investigations initiated and completed, the number and percentage of substantiated allegations, and time frames for completion of investigations. TennCare reviews incident reportable event and investigation data to ensure appropriate and timely remediation of identified findings. TennCare notifies DIDD, on a monthly basis, of any investigation findings that are not acceptably remediated. DIDD is required to provide additional information and/or take additional remedial action until TennCare can determine that appropriate remediation has taken place.

- Slight adjustments in Appendix G pertaining to restraints

Appendix G: Participant Safeguards

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When any restraint is used to ensure the health and safety of the person or others that was not anticipated, it will trigger notification to the Circle of Support, and the review and revision of the ~~ISP~~PCSP as appropriate, and as reflected above to address its use going forward.

When any behavior-related restraint is used, regardless of length of time used, type or approved by a plan, it must be reported as a ~~critical incident~~ reportable event.

Staff are required to use positive proactive and reactive strategies for preventing and minimizing the intensity and risk factors presented by an individual's behavior whenever possible in order to minimize the use of ~~personal and mechanic~~al behavior-related restraint~~s~~. Interventions that should be employed prior to the use of restraints must be documented in the ~~person centered ISP~~PCSP. Staff must be trained on the use of positive interventions and document that positive interventions were employed prior to the use of restraints.

Emergency ~~personal restraint, mechanical restraint~~ behavior-related restraints, or emergency medication (chemical restraint) ~~is~~ are used only as a last resort to protect the person or others from harm. The use of emergency ~~personal restraints or mechanical~~ restraints requires proper authorization, is limited to the time period during which it is absolutely necessary to protect the individual or others, and is not permitted as a punishment by staff, for staff convenience, or in lieu of person-centered programmatic services. The provider agency director or designee must ensure that staff are able to correctly apply the emergency ~~personal restraint or mechanical~~ restraint.

In cases where a behavior analyst assesses the level of behavior need and risk factors and the planning team concurs, the use of ~~personal or manual~~ restraints may be specified only as a Specialized Behavioral Safety Intervention for use in emergency circumstances, and not as an ongoing intervention or treatment in a behavior support plan that is reviewed and approved by the Circle of Support, including the person supported and his/her guardian/conservator, as applicable. The use of ~~personal or manual~~ restraints is limited to the time period during which it is absolutely necessary to protect the individual or others and is not permitted as a punishment by staff, for staff convenience, or in lieu of person-centered programmatic services.

Emergency use of ~~personal~~ restraints ~~or mechanical restraint~~ constitutes a reportable ~~incident~~ event and as such must comply with DIDD reporting procedures. The independent support coordinator must be notified of each use of emergency ~~personal or mechanical~~ restraints within 1 business day.

In addition, the use of psychotropic medications requires review by ~~a~~ the COS ~~human rights~~ and the provider reportable event review ~~committee~~ team. When emergency psychotropic medications are administered pursuant to physician's orders, a Reportable ~~Incident~~ Event Form must be completed and submitted.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency.

DIDD, the contracted operating agency, in conjunction with the MCOs, is responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed.

This involves a 100% review of all ~~incidents~~ reportable events reported in the DIDD ~~Incident~~ Reportable Event and Investigations Database on an ongoing basis.

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions may be utilized only as specified below, and with documentation in the person-centered plan of the following: the person's specific, individualized assessed need; the positive interventions and supports that are used prior to the use of restrictive interventions; the less intrusive methods of meeting the need that have been tried but did not work; a clear description of the condition that is directly proportionate to the specific assessed need; a requirement for regular collection and review of data to measure the ongoing effectiveness of the modification; established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; and an assurance that interventions and supports will cause no harm to the individual.

Restrictive interventions are only implemented as part of a behavior support plan approved by a Behavior Support Committee, the person's Circle of Support, and a Human Rights Committee (if necessary), and after informed written consent has been obtained from the person supported or the person's legal representative. ~~Person centered ISPs~~ PCSPs shall document positive interventions that are to be employed prior to the use of restrictive interventions.

A variance must be included in a behavior support plan and must be reviewed and approved by the individual and/or guardian or conservator, the Circle of Support, a Behavior Support Committee and Human Rights Committee as necessary, and by the Director of Behavior and Psychological Services. Final authorization must be provided by the Commissioner of the Department of Intellectual and Developmental Disabilities or designee.

All ~~incidents~~ reportable events involving the use of restraints are reported through the DIDD ~~incident~~ Reportable Event Management system. Regional Office Behavior Analysis staff routinely (daily, weekly, monthly, annually) review ~~incident~~ reportable event reports to determine inappropriate or excessive use of restraint.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DIDD, the contracted operating agency, in conjunction with the MCOs, is responsible for monitoring and overseeing the use of restrictive interventions.

The Quality Strategy includes performance measures specifically designed to facilitate discovery and remediation of the inappropriate use of restrictive interventions. ~~In this renewal application and in response to CMS modifications regarding waiver assurances and sub-assurances released in March 2014, the State modified its Quality Strategy to include performance measures specifically designed to facilitate discovery and remediation of the inappropriate use of restrictive interventions. New performance measures more closely reflect the State's monitoring and prevention efforts around these restrictive interventions.~~

Two ~~new~~ measures pertain specifically to seclusion and other restrictive interventions:

a.i.23 Number and percentage of reported events ~~critical incidents~~ NOT involving use of prohibited restrictive interventions. This involves a 100% review of all ~~incidents~~ reportable events reported in the DIDD ~~Incident~~ Reportable Event and Investigations Database on an ongoing basis.

Any instances of the inappropriate use of restrictive interventions will be promptly remediated.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

b. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DIDD, the contracted operating agency, in conjunction with the MCOs, is responsible for detecting the unauthorized use of seclusion.

In response to CMS modifications regarding waiver assurances and sub-assurances released in March 2014, the State modified its Quality Strategy to include performance measures specifically designed to facilitate discovery and remediation of the use of seclusion as well as the inappropriate use of other restrictive interventions. ~~New~~ These performance measures more closely reflect the State's monitoring and prevention efforts around these restrictive interventions.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DIDD Regional Office staff receive and review reportable ~~incident~~ event forms for completeness and determination of the nature of the ~~incident~~event. DIDD monitors for medication variance trends utilizing data from the ~~Incident~~ Reportable Event and Investigations database.

If a person supported is using a behavior modifying medication (including psychotropic medications, the DIDD Regional Quality Assurance surveyors will determine whether (1) there is documentation of voluntary, informed consent for the use of the medication; (2) the persons supported or the person's family member or guardian/conservator was provided information about the risks and benefits of the medication; and (3) the use of a behavior modifying medication as a restricted intervention was reviewed by the Circle of Support, the provider reportable event review team, Behavior Support and/or Human Rights Committees, as required.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

DIDD, in conjunction with the MCOs, is responsible for oversight of medication management.

Providers are required to complete a reportable ~~incident~~ event form for medication variances as specified by DIDD, and a copy of the DIDD Medication Variance Report is submitted with the RE/F. In all cases, medication administration by a person who was not trained and certified~~,~~ or was not licensed by the State of Tennessee to administer medications requires notification to the DIDD Investigations Hotline.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

The State is revising the sampling methodology for the following performance measures:

a.i.2. # and % of participant satisfaction survey respondents who indicated knowledge of how to report a complaint. (DIDD People Talking to People Consumer Survey question: Do you know how to report a complaint?). Percentage = survey respondents able to relate how to appropriately report a complaint / number of waiver participants in the sample who responded to this survey question. a.i.3. # and % of participant satisfaction survey respondents who reported being treated well by direct support staff. (DIDD People Talking to People Survey question: Do your support staff treat you well or with respect?) % = # of survey respondents who reported being treated well by direct support staff / total # of waiver participants in the sample who responded to this survey question. a.i.4. Number and percentage of participant satisfaction survey respondents who reported having sufficient privacy. (DIDD People Talking to People Survey question: Are you satisfied with the amount of privacy you have?) Percentage = survey respondents reporting sufficient privacy / total waiver participants in the sample who responded to this participant satisfaction survey question.

Sampling Approach *(check each that applies):*
☐ 100% Review
☑ Less than 100% Review
☐ ~~☑~~ Representative Sample Confidence Interval: ~~+/- 5%~~
☑ ☐ Stratified Describe Group: subgroups among the three grand regions in Tennessee (West, Middle, and East)

The State is adding the following new performance measure:

Data Source (Select one):

Other

If 'Other' is selected, specify:

DIDD Participant Satisfaction Survey

a.i.26. Number and percentage of participant satisfaction survey respondents who indicated knowledge of how to report abuse, neglect, and exploitation (People Talking to People Consumer Survey question: "If you see or experience abuse, neglect, or exploitation, do you know how to report it and to whom?") Percentage = Number of survey respondents able to relate how to appropriately report abuse, neglect, and exploitation / total number of waiver participants in the sample who responded to this survey question.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☑ Monthly	☑ Less than 100% Review
☐ Other Specify:	☐ Quarterly	☐ Representative Sample Confidence Interval:
	☐ Annually	☑ Stratified Describe Group: subgroups among the three grand regions in Tennessee (West, Middle, and East)
	☐ Continuously and Ongoing	☐ Other
	☐ Other Specify:	

The State is revising the following performance measure:

a.i.8. Number and percentage of ~~DIDD~~ investigations completed within 30 calendar days or with justifiable extenuating circumstances approved by DIDD Director of Investigations for any investigation not completed within 30 calendar days. Percentage = number of investigations completed within 30 days / total number of investigations completed during the reporting period.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Performance Measures a.i.1, ~~and~~ a.i.11, and a.i.25: A representative sample of waiver participants will be generated at the ~~beginning~~ end of the waiver year.

Performance Measures a.i.2, a.i.3, ~~and~~ a.i.4, and a.i.26: Data will be generated by contracted interviewers who complete DIDD People Talking to People Consumer Satisfaction Surveys. The minimum percentage of survey completion across all waivers is seven percent (7%) of the total combined waiver census.

Performance Measures a.i.8, ~~a.i.9, a.i.13~~ a.i.10, and a.i.23: Data describing reportable events and investigations is entered on an ongoing basis into the DIDD Reportable Events and Investigation Database.

Performance Measures a.i.17: The DIDD Customer-Focused Services (CFS) Unit is responsible for reporting complaint resolution strategies and timeframes required for complaint resolution to the DIDD ~~Complaint~~ CFS Coordinator.

Performance measure a.i.22 is reviewed by the DIDD Director of Behavioral/Psychiatric Services. All Behavior Support Plans including restrictive interventions are reviewed to ensure that restrictive interventions comply with policies and procedures.

Performance Measures a.i.~~22~~ 20 and a.i.~~25~~ 21 are reviewed during DIDD Quality Assurance (QA) Surveys.

Methods for Remediation/Fixing Individual Problems
i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Performance Measures a.i.2, a.i.3, ~~and~~ a.i.4, and a.i.26: When individuals do not know how to report complaints and/or abuse, neglect, or exploitation, the satisfaction survey interviewer will provide the appropriate information. The DIDD People Talking to People Director or designee will contact the waiver participant and/or person assisting the waiver participant who received complaint and/or abuse, neglect, and exploitation reporting instruction within 60 days to verify that the person who received information knows how to report complaints and/or abuse, neglect, and exploitation and has the appropriate written resources describing reporting processes. On a monthly basis, the DIDD People Talking to People Director will report information regarding the number of survey respondents who did not know how to appropriately report a complaint and/or abuse, neglect, or exploitation, as well as education provided and verifications completed, to DIDD Central Office staff responsible for data aggregation.

When waiver participants report that they have not been treated well or are dissatisfied with the amount of privacy allowed, the interviewer will determine how circumstances failed to meet expectations, when any specific event(s) described happened, and if the waiver participant wants to file a complaint or take other action, such as attending self-advocacy meetings or amending the ~~Individual Support Plan~~ PCSP.

Performance Measures a.i.8, ~~a.i.9, a.i.13~~ a.i.10, and a.i.19: Individual issues identified during DIDD investigations are reported to involved providers, who are required to respond within 30 days to identify corrective actions to be taken.

Performance Measure a.i.22: ~~The DIDD Director of Behavioral Services will review~~ For behavior support plans (BSPs) ~~to ensure~~ that ~~they~~ do not comply with state policies and procedures related to restrictive interventions, DIDD will require the Behavior Service provider to revise the BSP to comply with policies and procedures for restrictive interventions.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability language will be modified as follows:

The ~~Department of Intellectual and Developmental Disabilities (DIDD)~~ MCOs require~~s~~ providers receiving $750,000 or more in aggregate state and federal funds to obtain an independent audit of the organization and to submit copies of the independent audit to the Tennessee Office of the Comptroller and to the DIDD Office of Risk Management and Licensure.

The Fiscal Accountability Review (FAR) unit of the Office of Quality Management conducts annual ~~on-site~~ reviews of all applicable providers, per policy, to determine compliance with the Independent Audit requirement.

Fiscal Accountability Review (FAR) – The DIDD Office of Quality Management, Fiscal Accountability Review (FAR) Unit monitors contracts and conducts ~~onsite~~ reviews.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

a.i.4 Number and percentage of rates approved that are consistent with the approved rate methodology throughout the five year waiver cycle. Number of claims ~~received~~ submitted with billed amounts ~~more than~~ consistent with the approved waiver max fee schedule~~, which are automatically reduced to be paid according to the approved rate methodology~~/ total number of submitted claims.

b. Methods for Remediation/Fixing Individual Problems will be modified to reflect changes related to the processing of claims by MCOs.

Performance Measure a.i.1 and a.i.4: ~~The~~ TennCare's contracted MCO will process waiver claims and pay contracted providers at the rates established by the State. Claims are also processed against a number of other edits or audits specific to service limits within the DIDD billing system and MCO claims systems. The MCO will provide a remittance advice to each provider and a consolidated 835 file to DIDD. ~~MMIS system generates a Remittance Advice Report~~ listing the status of all submitted claims~~, including those approved, those denied, and those suspended. DIDD Administrative Unit staff receive reports following each billing cycle. DIDD must correct errors, based on the reason for denial specified in the report, and resubmit the corrected claims within six months the 120-day timely filing period. If the error is not appropriately corrected upon resubmission, the claim will be denied again. Upon second denial of a claim, TennCare will issue a written notice to DIDD indicating that a resubmitted claim was denied and cannot be paid until errors are appropriately corrected. TennCare will provide technical assistance as needed to ensure correction of the error. TennCare~~ MCOs will report to TennCare each month the number and total value of claims denied, and the reason for such denials. MCOs and TennCare Claims will ~~also~~ report each month the number and percentage of claims correctly billed with correct billing codes and service rates and the number and total value of claims with billed amounts that exceeded the TennCare-approved fee schedule. ~~total value of claims with billed amounts that exceeded the TennCare approved fee schedule, and for which payment was reduced accordingly.~~ TennCare will review this data each month and will track and trend the data over the remainder of the five-year waiver period and follow up with DIDD and/or the MCOs to address repeated billing errors or concerns. ~~will track the number of claims denied multiple times for the same error. If more than two denials are generated for the same claim error,~~ TennCare will send a written notice to DIDD and/or the MCOs requesting corrective action when determined necessary, which may include procedural changes, staff training, or staff disciplinary actions. DIDD and/or the MCOs will be required to respond with a written explanation of the corrective actions taken within 30 days of receiving the TennCare request for corrective action. ~~Suspended claims are reviewed by designated TennCare staff for determination of the reasons and appropriateness of suspension. TennCare staff will work toward correction of any issues causing the claim to suspend until they are resolved and result in approval or denial of the claim.~~

~~The TennCare MMIS system has edits in place to automatically deny claims that are not consistent with the approved rate methodology. The TennCare Information Systems Unit reports monthly to confirm that no claims have been paid that are inconsistent with that methodology.~~

~~Performance Measure a.i.4: The state will ensure that the rates approved are consistent with the approved rate methodology throughout the five year waiver cycle, and report cases that vary from the approved rate, if applicable.~~

The State Medicaid Agency will also be added (along with the Operating Agency) as an entity responsible for Remediation-related Data Aggregation and Analysis.

I-2: Rates, Billing and Claims (1 of 3) will be modified to reflect adjustments to rate determination methods and flow of billings as described below.

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

MCOs will reimburse contracted providers for waiver services at the rates specified by TennCare. Rates that will be paid by MCOs are carried forward from the fee-for-service program and adjusted as needed to ensure an adequate network of qualified providers to deliver waiver services. ~~Proposed service rates are determined by the Department of Intellectual and Developmental Disabilities (DIDD) and are reviewed and approved by TennCare, the State Medicaid Agency, which has oversight of the rate determination process. TennCare keys approved rates into the MMIS sends approved rates to contracted MCOs for purposes of processing claims for waiver services. The methodology used to determine rates is outlined in Chapter 0465-01-02 of DIDD's Administrative Rules and can be found at this link: https://publications.tnsosfiles.com/rules/0465/0465-01/0465-01-02.20200105.pdf http://publications.tnsosfiles.com/rules/0465/0465-01/0465-01-02.20140312.pdf~~

~~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. The rates for this waiver were restructured in 2005 with the average expenses incurred by providers in 2004 used as the cost model. DIDD continues to make adjustments to the 2005 rates, particularly the direct support professional hourly wage component within the rates, based on feedback from providers and current employment trends.~~

~~The state has appropriated an additional $46.431.6 million in state funds since state fiscal year 2014 for provider rate increases across all waiver programs. DIDD has no formal process in place to review provider costs; however, DIDD regularly meets with providers at Statewide Planning and Policy Council meetings as well as other providers meetings and rates are discussed. Additionally, DIDD has one staff person that routinely reviews cost data for providers who are struggling financially and have requested technical financial assistance. Rates must be sufficient to recruit an adequate supply of qualified providers for each service to ensure participants statewide have adequate access to waiver services.~~ In setting rates, the rates for similar services in other states and other in-state programs are considered, ~~and rates are adjusted based on the number of waiver participants receiving services in a group arrangement,~~ where applicable. ~~Rates paid in this waiver are the same as those paid in the two other 1915(c) home and community-based waivers for people with intellectual disabilities. Providers are reimbursed up to the maximum allowable rate established for a service.~~ Information about payment rates is made public on the TennCare or DIDD web site, i.e., TennCare Maximum Reimbursement Rate Schedule.

Stakeholders have the opportunity to provide input into the development and sufficiency of rates through the posting of waiver renewals and amendments for public comment, the DIDD Statewide Planning and Policy Councils, provider meetings, and other public meetings~~, as well as through the DIDD rule-making hearing process, which includes public notice and a rule-making hearing~~.

Quality Payment for Hours Worked Milestone under Supported Employment-Individual Employment Support: Payment earned and paid for additional/atypical effort of provider that results in a waiver participant working in competitive integrated employment achieving above average hours worked in a six-month period.

To support the introduction of TennCare and DIDD Value-Based Purchasing (VBP) initiatives, a flexible residential service rate option is available to incentivize provider outcomes that align with system transformation values, such as person-centered practices, independence, community integration, dignity of choice, competitive integrated employment, enabling technology, and workforce development.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All Waiver services are prior approved by DIDD. Providers submit invoices for delivered services to the DIDD central office. The DIDD system has numerous edits including an edit that verifies the services provided on the date of service were approved in the participant's ~~I~~PCSP.

The DIDD system converts the provider claims that successfully process through all of its edits to the ~~HIPAA compliant institutional~~ appropriate claim format and submits the claims electronically to TennCare ~~for processing through the MMIS~~. TennCare's ~~he~~ MMIS contractor will then separate the claims by MCO. Each MCO will receive a file of claims for their members. The MCO will process the claims and pay the providers at the rates established by the State and provide a remittance advice to each provider, a consolidated 835 file to DIDD, and an 837 encounter file to TennCare.

Commented [EI19]: This language currently in Statewide Waiver and being added to CAC Waiver to replace the following: *"to assist waiver participant to obtain and retain competitive integrated employment where hours worked are substantially higher than the average for all waiver participants"*

~~processes the claims and returns the remittance advices electronically to DIDD and posts an electronic remittance advice on TennCare's provider portal, allowing each provider to securely access their remittance advices. TennCare issues reimbursement payments to the providers.~~ Providers retain 100% of the payment ~~calculated~~ reflected as encounters in the MMIS and reported on the CMS 372 report.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3) will be modified to reflect adjustments to the billing validation process as described below.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

DIDD or the MCO with DIDD oversight approves services in the PCI~~S~~P. All providers submit service invoices to DIDD. The DIDD system validates service invoices against the ~~DIDD~~ approved service plans. The DIDD system creates a claim for services that were in an approved plan and submits the claims to TennCare ~~for processing through the MMIS~~. TennCare's MMIS contractor will then separate the claims by MCO. Each MCO will receive a file of claims for their members. When the claims are processed by the MCO, ~~through the MMIS,~~ the system checks to verify that the person had an active Pre-Admission Evaluation establishing waiver eligibility, and the person's eligibility for Medicaid on the date of service is verified, using eligibility data provided to the MCO on the 834. Claims are also processed against a number of other edits or audits specific to service limits within the ~~MMIS~~MCO claims systems. Post-payment reviews are conducted by the DIDD Internal Audit Unit and by TennCare to ensure services were provided.

Appendix I: Financial Accountability I-3: Payment (1 of 7)

b. Method of Payments – MMIS (select one): will be modified to reflect that "Payments for waiver services are made by a managed care entity or entities [rather than by the MMIS]." While the CMS template for this section also states that "The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS," the description will explain that the payment method is not a monthly capitated payment, but that payments made by the MCO for waiver services and reimbursed by TennCare will be reflected in the MMIS as encounters.

TennCare contracts with MCOs that provide physical, behavioral, and -beginning ~~July 1, 2021~~January 1, 2023, 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.

Appendix I: Financial Accountability

I-3: Payment (2 of 7) b. Direct payment will be modified to reflect that "Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity."

Appendix I Financial Accountability, I-3(g)ii, will be modified to reflect that, "The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10." All current language in that section will be deleted, as all waiver services will be delivered through managed care pursuant to concurrent 1115 waiver authority.

Appendix I Financial Accountability, I-3(g)iii, will be modified to reflect that, "This waiver is a part of a concurrent 1115/1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid

inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The 1115 waiver specifies the types of health plans that are used and how payments to these plans are made."

Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (4 of 9)

Component management for a waiver service. Enter the component name in the text box provided and click "Add." Multiple components can be added to each service. To return to the previous screen select "Return to List of Services."

The State is adding the following VBP Flexible Residential Rate service component to the Supported Living service in the CAC and Statewide waivers:

Supported Living

Component Name
Supported Living
Companion Model – Room & Board
Supported Living Special Needs Adjustment
Residential Special Needs Adjustment Homebound
VBP Flexible Residential Rate

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

As provided in 42 CFR §440.180(b) (9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Support Coordination

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select

☐ Service is included in approved waiver. There is no change in service specifications.

☑ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in the approved waiver.

Service Definition (Scope):

Character Count = 12,000

Support Coordination shall mean the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities to identify and achieve individualized goals related to work (in competitive, integrated employment), ~~develop~~ personal relationships, ~~participate in their~~ community involvement,

understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness ~~develop the skills and abilities needed to achieve these goals, person supported~~ as specified in ~~person supported~~ the ~~individual's person-centered Individual~~Person-Centered Support Plan (~~ISP~~PCSP), and the tracking and measurement of progress and outcomes related to such individualized goals, as well as the provider's performance in supporting the person's achievement of these goals. Support Coordination shall be provided in a manner that comports fully with standards applicable to person-centered planning for services delivered under Section 1915(c) of the Social Security Act.

Specific tasks performed by the Support Coordination provider shall include, but are not limited to general education about the waiver program and services, including individual rights and responsibilities; providing necessary information and support to the individual to support his/her direction of the person-centered planning process to the maximum extent desired and possible; initial and ongoing assessment of the individual's strengths, ~~and~~ needs and preferences, including an understanding of what is important to and important for the person supported and the development of a PCSP that effectively communicates that information to those providing supports; identification and articulation in the PCSP of the person's individualized goals related to work, personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness, and actions necessary to support the person in achieving those outcomes; leveraging individual strengths, resources and opportunities available in the person's community, and natural supports available to the person or that can be developed in coordination with paid waiver services and other services and supports to implement identified action steps and enable the person to achieve his/her desired lifestyle and individualized goals for employment, personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and self-determination, and personal health and wellness; initial and ongoing assessment of how Enabling Technology could be used to support the person's achievement of individualized goals and outcomes, and planning and facilitation of Enabling Technology supports, as appropriate; facilitating an employment informed choice process with the expectation of exploring employment and supporting the person to make informed choices about work and other integrated service options; ~~of what is important to the individual, including preferences for the delivery of services and supports~~; actual development, implementation, monitoring, ongoing evaluation, and updates to the ~~ISP~~PCSP as needed or upon request of the individual; additional tasks and responsibilities related to consumer direction of services eligible for consumer direction, as prescribed by TennCare; coordination with the individual's MCO and physical and behavioral health care providers and HCBS providers to improve and maintain health, support personal health and wellness goals, manage chronic conditions, and ensure timely access to and receipt of needed physical and behavioral health services; supporting the individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS; assuring the personal rights of freedoms of persons supported, and supporting dignity of choice, including the right to exercise independence in making decisions, and facilitation of supported decision making when appropriate; identification and mitigation of risks to help support personal choice and independence, while assuring health and safety; specific documentation of any modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes prescribed in federal and state regulation and protocol; and monitoring implementation of the ~~ISP~~PCSP and

initiating updates as needed and addressing concerns which may include reporting to management level staff within the provider agency; or reporting to DIDD when resolution is not achieved and the ~~ISP~~PCSP is not being implemented. The ISC will provide the individual with information about self-advocacy groups and self-determination opportunities and assist in securing needed transportation supports for these opportunities when specified in the ~~ISP~~PCSP or upon request of the individual. Ongoing monitoring by ISCs is accomplished through a stratified approach, based on the person's assessed level of support need, as follows: 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 ~~a minimum of~~ at least one ~~monthly~~ in-person or telephone contact per calendar month with an in-person contact occurring at least every other month. At least once every three months, for level of need 1, 2, or 3 residential services (Supported Living, Residential Habilitation, and Family Model Residential), a visit must occur in the person's home; and 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. ~~and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home.~~ 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 ~~a minimum of~~ at least one ~~monthly~~ face-to-face contact per calendar month ~~across all environments and in the person's residence at least quarterly~~. 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. At least once every three months, for level of need 4, 5, or 6 residential services (Supported Living, Residential Habilitation, Medical Residential, and Family Model Residential), a visit must occur in the person's home; or 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.

The level of need for reimbursement of residential services is the overriding determinant of the type and frequency of contacts. The level of need or employment and day services will determine type and frequency of contacts only if the person receives no residential services.

~~Residential level of reimbursement is the overriding determinant of the contact frequency. Day services level of need will only determine visit frequency if the person receives no residential services.~~ Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ~~ISP~~PCSP for that person per service received across service settings. In addition to general assurance of health and safety, the purpose of this review shall be to ensure that services and supports are being provided in accordance with the PCSP and are appropriate to support the achievement of individualized goals and outcomes. Progress toward goals and outcomes shall be reported as part of the Monthly Status Review. ~~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.~~

The ISC may, if preferred by the person and/or legal guardian, if applicable, and documented in the PCSP, complete *some* of the minimally required visits using telehealth-specifically online videoconferencing using a tablet or other smart mobile device. If virtual technology is not available to the person, then a telephone contact may be acceptable to allow flexibility per the family's request. All of the following, at a minimum, shall require in-person face-to-face visits, absent extenuating circumstances such when an in-person meeting may negatively impact the person or coordinator's health or safety:

(1) Annual re-assessment or planning meeting for purposes of updating the PCSP;

~~(2) Quarterly visits for persons assessed to have level of need 1, 2, or 3 for purposes of reimbursement of residential services (Supported Living, Residential Habilitation, and Family Model Residential), and persons not receiving any residential or day service reimbursed based on level of need;~~

~~(3) Bi-monthly visits for persons assessed to have level of need 4 for purposes of reimbursement of residential services (Supported Living, Residential Habilitation, and Family Model Residential);~~

~~(4) Monthly visits for persons assessed to have level of need 5 or 6 for purposes of reimbursement of residential services (Medical Residential Services, Supported Living and Residential Habilitation); and~~

(~~5~~2) When there is a significant change in condition defined as:

a. Change in community placement to a residential setting (i.e. Supported Living, Medical Residential) or a change between residential settings;

b. Loss or change in primary caregiver or loss of essential social supports for a person not receiving residential services;

c. Significant change in physical or behavioral health and/or functional status, including but not limited to hospital (acute or psychiatric) admission for purposes of ensuring appropriate supports are available upon discharge; following any hospital discharge (to ensure the person's needs are being met, ensure continuity of care, and avoid potential readmission; following any out-of-home placement related to behavior support needs; ~~or~~

d. Repeated instances of reportable events; or

e. Any other event that significantly increases the perceived risk to a person~~.~~; and

(3) At any time based on the member's preference for in-person meetings.

The Support Coordination provider shall initiate and oversee at least annual reassessment of the individual's level of care eligibility, and initial and at least annual assessment of the individual's experience to confirm that that the setting in which the individual is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the ~~person-centered ISP~~PCSP. The Individual Experience Assessment shall be completed as prescribed by TennCare and the Support Coordination provider shall help to facilitate prompt remediation of any findings. The Employment Data Survey shall also be completed as prescribed by TennCare.

To support the introduction of TennCare and DIDD Value-Based Purchasing (VBP) initiatives, a flexible

residential service rate option is available to incentivize provider outcomes that align with system transformation values, such as person-centered practices, independence, community integration, dignity of choice, competitive integrated employment, enabling technology, and workforce development.

Provider Specifications:

Provider Category	Provider Type
Individual	~~Individual~~ Independent Support Coordinator
Agency	ISC Service Agency

Provider Specifications:

Provider Category	Provider Type	

Individual	~~Individual~~ Independent Support Coordinator	View Provider Link
Agency	ISC Service Agency	View Provider Link
		View Provider Link

ENABLING TECHNOLOGY WAIVER DEFINITION AND OPTIONS

Enabling Technology is equipment and/or **methodologies** that, alone or in combination with associated technologies, provides the means to support the individual's increased independence in their **homes, communities, and workplaces**. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform daily tasks that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation.

Enabling Technology includes remote support technology systems in which **remote support staff and/or coaches and/or natural supports can interact, coordinate supports**, or actively respond to needs in person when needed. Remote support systems are real time support systems which **often** include two- way communication.

Enabling technology is an available support option for all aspects and places of participants' lives.

- These systems use wireless technology, and/or phone lines, to link an individual's home to a person off-site to provide up to 24/7 support.
- These systems include the use of remote sensor technology to send "real time" data remote staff or family who are immediately available to assess the situation and provide assistance according to a Person-Centered Support Plan (PCSP).

Examples of enabling technologies typically used in peoples' homes include:

- Motion sensors
- Smoke and carbon monoxide alarms
- Bed and/or chair sensors
- Live or on demand audio and/or video technologies
- Pressure sensors
- Stove guards
- Live web-based remote supports
- Automated medication dispenser systems
- Mobile software applications using digital pictures, audio and video to guide, teach, or remind
- GPS guidance devices
- Wearable and virtual technologies
- Software to operate devices for environmental control or to communicate with other smart devices, paid or natural supports at home, at work, or any other place of personal import.

EMPLOYMENT & DAY SUPPORTS

Mobile Technologies to teach safe travel skills and guide people during community travel to work or other places important in their lives, by walking or using public transportation.

Enabling technology options include:

- Mobile software applications using digital pictures, audio and video to guide, teach, or remind
- GPS guidance devices
- Wearable and virtual technologies
- Software to support communication with people along participants' routes or destinations.

Rideshare/ Community Transportation

Pre-authorization of (up to) a $500 coupon code or pass per month based on person's travel plans or needs, (work, school, shopping, movies, etc.).

This waiver benefit can also be used to pay a car pooler back for gas, for bus fare, a taxi service, etc.

PRE-EMPLOYMENT:
EXPLORATION

Digital Career Exploration
Self-directed or guided exploration of jobs and job tasks via a computer environment or a smart device's software application using digital pictures, audio and video to enable participants and job developers to identify jobs that match the individual's job interests.

Digital tools for interest/skill exploration, member background information, scenario activities to identify skill set, learning styles, support needs.

Virtual Reality
Jobseekers can experience first-hand the pros and cons of various occupations by seeing, hearing and feeling what they are actually like.

PRE-EMPLOYMENT: DISCOVERY/JOB DEVELOPMENT

Online tools for job hunting such as job boards;
job interview tasks & tips, conditions for success, job/skill evaluations, scenario activities.

REMOTE COACHING

Job Coaching includes supports provided to the person and their supervisor or co-workers, either remotely (via technology) or face-to-face.

A device that otherwise meets the requirement for two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system.

Mobile technologies, video modeling, task prompting software applications, GPS-based applications; wearable technologies; virtual, augmented, mixed reality systems.

FADING

A mobile technology that offers long-term support on the job, in lieu of paid support, that may encompass job tasks, social behavior, or communication.

The use of enabling and/ or mobile technologies to support fading may cover a wide array of person- centered needs that include attendance, punctuality, self-managing breaks, interpersonal skills, appearance, communication, sequencing job tasks, etc.

LIMITATIONS

The service limit for Specialized Medical Equipment, Supplies, and Assistive Technology encompasses both Specialized Medical Equipment, Supplies, and Assistive Technology as well as Enabling Technology, i.e., a $10,000 limit per 2 waiver years across both services.

Nursing Services

Nursing Services shall mean skilled nursing tasks that must be performed by a registered or licensed nurse pursuant to Tennessee's Nurse Practice Act and that are directly provided to the person supported in accordance with a person-centered ~~ISP~~ support plan (PCSP).

Nursing Services shall be ordered by the physician, physician assistant, or nurse practitioner of the person supported, who shall document the medical necessity of the services and specify the nature and frequency of each of the skilled nursing tasks to be performed. Except as permitted herein, Nursing Services shall be provided (and shall be eligible for reimbursement only if provided) face-to-face with the person supported by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse, hereinafter referred to as "direct Nursing Services."

When direct Nursing Services are provided, the nurse shall also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the person supported during the period that Nursing Services are authorized and provided, unless such assistance cannot be safely provided by the nurse while also attending to the skilled nursing needs of the person supported (which must be documented in writing and approved pursuant to protocol). However, the ~~amount~~ units of Nursing Services authorized and provided shall depend only on the skilled nursing needs of the person supported. Additional Nursing Services shall not be authorized only for purposes of providing unskilled needs. Nor shall Nursing Services be authorized for a continuous period (e.g., for several hours or a shift) if skilled nursing tasks are not needed continuously--at least hourly during such period.

When Nursing Services are provided as a shared service for 2 or more individuals residing in the same home (regardless of funding source), the total number of units of shared Nursing Services shall be apportioned based on the total units of nursing services prescribed for each person supported, and the apportioned amount shall be specified in the ~~ISP~~ PCSP for each person supported, as applicable.

Such "Nursing Services for Delegation" shall be reimbursed at the rate specified.

Effective upon issuance of rules by TennCare to effectuate statutory authority related to self-direction of health care tasks as specified in 71-5-1414, Nursing Services shall also include the provision of services to teach and support paid caregivers in the performance of self-directed health care tasks beyond medication administration. Services may include face-to-face training of a person's DSP(s) on the person's self-directed health care task(s) before beginning to perform such task(s), before performing newly ordered task(s), or to monitor and support the safe performance of self-directed health care tasks on a periodic basis. "Nursing Services for Self-Direction of Health Care Tasks" shall be reimbursed at the rate specified for these tasks. Nursing Services for Self-Direction of Health Care Tasks may also include the provision of services via telehealth only when a DSP performing a health care task who has previously completed training or the person supported (or his authorized health care representative) requests additional training or consultation in order to ensure the safe and appropriate performance of a self-directed health care task.

Nursing Services shall consist of ~~2~~ 5 categories of services and reimbursement:

a. Direct RN services: RN services shall mean direct skilled nursing services, as specified above, which are provided face-to-face by a registered nurse. This includes those services which require the skills of a registered nurse and which are required by Tennessee's Nurse Practice Act to be performed by a registered nurse.

b. Direct LPN services: LPN services shall mean direct skilled nursing services, as specified above, which are provided face-to-face by a licensed practical nurse working under the supervision of a registered nurse and which are permitted by Tennessee's Nurse Practice Act to be performed by a licensed practical nurse working under the supervision of a registered nurse.

c. RN Nursing Services for Delegation shall mean the services described above.

d. RN Nursing Services for Self-Directed Health Care Tasks shall mean the services described above which shall be provided face-to-face with the person supported and the DSP(s).

e. RN Nursing Services for Self-Directed Health Care Tasks via Telehealth shall mean the services described above which may be provided via telehealth with the person supported and the DSP(s). The provision of the service via telehealth requires online videoconferencing using a tablet or other smart mobile device. The service may not be provided telephonically.

Commented [EI20]: These rates remain unchanged.

Commented [EI21]: Proposed rate $25/quarter hour

Commented [EI22]: Proposed rate $15/quarter hour (there is no travel/time lost); this is the ONLY nursing service that may be delivered via telehealth, as the hands on skilled task is being performed by the trained caregiver.

~~This service~~ Nursing Services shall be provided in home and community settings, as specified in the PC~~I~~SP, excluding schools, inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

LIMITATIONS

Nursing Services shall be limited to a maximum of 48 units (12 hours) per day per waiver participant. The limit applies across all categories of nursing services and reimbursement.

Additional limitations: Nursing Services for Delegation shall be limited to a maximum of four (4) units per initial training to a paid or unpaid caregiver and a maximum of two (2) units per instance of ongoing evaluation, teaching training. Ongoing evaluation, teaching and training of a paid or unpaid caregiver is generally expected to occur no more than weekly during the first month, and no more than monthly thereafter, and only as needed to ensure the task is being safely and properly performed.

Nursing Services for Self-Directed Health Care Tasks shall be limited to a maximum of four (4) units per initial training of the health care task to a DSP. Nursing Services for Self-Directed Health Care Tasks shall be limited to a maximum of two (2) units per instance of monitoring and support of self-directed health care tasks, whether performed face-to-face or via telehealth. Monitoring and supporting the safe performance of self-directed health care tasks on a periodic basis.is generally expected to occur no more than weekly during the first month, and no more than monthly thereafter, and only as needed to ensure the task is being safely and properly performed.

A Concept Paper and Joint Plan
to Transform Tennessee's Service Delivery System
for Individuals with Intellectual and Developmental Disabilities

The Department of Intellectual and Developmental Disabilities (DIDD) is the state agency responsible for administering services and support to Tennesseans with intellectual and developmental disabilities (I/DD).

Our mission is:

To become the nation's most person-centered and cost-effective state support system for people with intellectual and developmental disabilities.

We envision a world where we:

*Support **all** Tennesseans with intellectual and developmental disabilities to live the lives they envision for themselves.*

There are multiple barriers to achieving this vision.

Currently, there are more than 5,000 people with I/DD on a waiting list to receive services and supports, with more than 4,000 of those individuals seeking to receive services now. Our ability to achieve our vision depends on achieving our mission—providing supports that are **both** person-centered **and** cost-effective in order to allow us to use limited resources to support **all** Tennesseans with I/DD to live the lives they envision.

Also critical to our vision is that today, DIDD operates *some* of the programs and services for individuals with I/DD in Tennessee—three Medicaid Home and Community Based Services (HCBS) waiver programs, state-operated Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICFs/IID), and the Family Support Program. We are also the lead agency for the Tennessee Early Intervention System. However, other components of the delivery system for people with I/DD are not currently operated by DIDD. These include the Employment and Community First CHOICES program (operated by the Division of TennCare through the managed care program) and private ICF/IID services (delivered through fee-for-service contracts with TennCare). While we collaborate with TennCare around the delivery of these services, DIDD is not *leading* the delivery of these services, bringing to the day-to-day operation of these programs our expertise and commitment in serving people with I/DD and their families.

Finally, the lives that people envision for themselves are rarely lives of dependence. Like all of us, they want to work, be part of their communities, have meaningful relationships, and achieve personal goals. They want to go where they want, do the things they want, with the people they want, and with as much independence and self-determination as possible. We

July 2020

need a system—a single aligned person-centered system that supports each person with an *expectation* of helping them live the life they want in their communities, that supports growth and independence, and delivers on personal outcomes.

During the multi-year strategic planning process, as part of an overarching goal to transform the service delivery system for people with I/DD, DIDD and TennCare committed to develop a model working partnership in order to accomplish the following strategic objectives:

- **Eliminate the waiting list** of persons with I/DD who are actively seeking to enroll in Medicaid services.
- Embed person-centered thinking, planning and practices and align key requirements and process across Medicaid programs and authorities in order to **create a single, seamless person-centered system of service delivery for people with I/DD**, including:
    - Critical incident management;
    - Quality assurance and improvement;
    - Direct support workforce training and qualifications;
    - Provider qualifications and enrollment/credentialing processes;
    - Value-based reimbursement approaches aligned with system values and outcomes.
- **Increase the capacity, competency and consistency of the direct support workforce**.
- **Support the independence, integration, and competitive, integrated employment of individuals with I/DD** through the use of effective person-centered planning, enabling technology, and the development of natural supports as evidenced by an increase in the number of working age adults participating in competitive, integrated employment, and the transition of persons supported to less intensive support arrangements based on individualized needs and preferences.
- **Integrate the budgeting process** for programs and services for people with I/DD in order to best meet the needs of all Tennesseans with I/DD and their families.

While the budgetary challenges brought on by the COVID-19 public health emergency brought unanticipated challenges to achieving this goal (i.e., the loss of previously approved funding to serve 2,000 people from the waiting list), it has also brought opportunity—the need to take bold action that will have significantly greater impact in achieving **all** of these strategic objectives.

DIDD and TennCare plan to integrate all Medicaid programs and services for individuals with I/DD—including Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID), the Section 1915(c) home- and community-

based services (HCBS) waivers, and Employment and Community First CHOICES[1] into the managed care program, under the direct operational leadership, management, and oversight of DIDD.

Doing so will yield an immediate increase in state revenues - $34.4 million, which will assist in limiting benefit or provider reimbursement cuts in these waivers as part of necessary state budget reductions.

However, this transformational change will have far more significant benefits than these increased revenues.

- First, it will finally and fully achieve the vision of **a single, seamless person-centered system of service delivery for people with I/DD**. By bringing all of these programs, populations, and services together under the direct operational leadership, management, and oversight of DIDD, Tennessee can align critical incident management, quality assurance and improvement, direct support workforce training and qualifications, and provider qualifications and enrollment/credentialing processes—reducing administrative burden for providers. Providers have long sought not just alignment, but *person-centered* alignment, that minimizes some of the restrictive and burdensome expectations that have resulted from the impact of longstanding litigation.
- It will set the stage for new **value-based reimbursement** approaches aligned with system values and outcomes. These value-based approaches will be specifically designed to support the independence, integration, and competitive, integrated employment of individuals with I/DD through the use of effective person-centered planning, technology first approach, and the development of natural supports as evidenced by an increase in the number of working age adults participating in competitive, integrated employment, and the transition of persons supported to less intensive support arrangements based on individualized needs and preferences. This will be beneficial in multiple ways:
    - Most importantly, it will **help persons supported live better lives in the community with as much independence as possible**.
    - It will **utilize limited staffing resources much more efficiently**, addressing critical workforce shortages and creating additional workforce capacity to serve additional people.
    - It will allow for **a much more efficient and effective use of state and federal Medicaid resources** to serve the I/DD population. By integrating the budget process for programs and services for people with I/DD and providing services more efficiently, we will be able to utilize existing program resources to serve additional people with I/DD from the current waiting list.

[1] Employment and Community First CHOICES is already part of the managed care program, but not under the direct operational leadership, management and oversight of DIDD.

In the absence of the funding that had been appropriated to serve people from the waiting list, it provides a pathway (subject to the budget process) to achieving the goal of eliminating the waiting list that will otherwise not be available, at least in the near future.

Proposed New System Structure

Under the transformed service delivery system for people with I/DD, all long-term services and supports (LTSS) for individuals with I/DD will be part of the managed care program. They will be administered through the managed care program under the direct operational leadership, management, and oversight of DIDD.

TennCare will contract with DIDD to serve as the operational lead agency for all I/DD programs and services.

TennCare and DIDD, will in turn, contract jointly with Managed Care Organizations, with DIDD leading the day-to-day management and oversight of the MCO contracts for I/DD benefits, and TennCare working alongside DIDD and continuing to lead management and oversight of other integrated benefit components for the I/DD population—physical and behavioral health, pharmacy, and dental services, in consultation and partnership with DIDD. This partnership and shared leadership responsibility will be particularly critical as it relates to building the statewide capacity and continuum of the behavioral health system to meet the needs of individuals with I/DD who have co-occurring mental health conditions or behavior support needs in a person-centered way (moving toward independence and integration to the maximum extent appropriate), including:

- The development and engagement of statewide HCBS provider networks, including workforce capacity, to serve people with I/DD and co-occurring behavior support needs;
- The development of statewide capacity for behavioral crisis response and stabilization, leveraging telehealth with in-person backup as needed; and
- The development of statewide capacity for rapid placement, stabilization and assessment, including person-centered transition planning with the HCBS provider and/or family caregiver (as applicable); program development and implementation (including training), and post-transition stabilization placement support (telehealth and in-person).

Authority

TennCare will maintain the existing 1915(c) waivers, with modifications as determined by TennCare and DIDD to be needed, with input from our stakeholders.

TennCare will submit an 1115 waiver request for concurrent 1115 demonstration authority to bring these waivers and the ICF/IID benefit under the managed care program and to operate these services, along with Employment and Community First CHOICES, as part of single, seamless person-centered system of service delivery for people with I/DD.

Timing and Funding

To implement this plan, we will be seeking the necessary federal authority through the renewal of the TennCare demonstration waiver from the Centers for Medicare and Medicaid Services (CMS). While the timeline for implementation is uncertain, considering the federal approval process and the necessary IT system upgrades, and other needed changes for integration to occur, our goal is to have full integration by July 1, 2021.

Overview of Proposed Amendments and Changes to Integrate and Transform Long-Term Services and Supports (LTSS) for People with Intellectual and Developmental Disabilities (I/DD)

Key

We are listening…

Throughout this document, we use this icon to point out some of the ways in which input is specifically reflected in the proposed plan.

We want you to know…

Throughout this document, we use this icon to highlight some of the most important messages or ideas.

Overview of Proposed Amendments and Changes to Integrate and Transform LTSS for Individuals with I/DD

Introduction

In Tennessee and across the nation, people living with intellectual and developmental disabilities (I/DD) are experiencing life in a very different way than they were even a decade or so ago. Tennessee has made tremendous progress and is proud to have left large congregate institutions behind, turning staunchly toward an approach that is person-centered and understands that people with disabilities want to live their lives on their own terms, in their own homes and communities. They want (and indeed *are entitled* under the law to) the same rights and freedoms, the same opportunities to work and participate fully in all aspects of community life.

And yet we must continually ask ourselves if these values are evident in our Medicaid policies, programs, and payment systems. Do our outcomes support that people with I/DD are indeed supported to work in integrated settings earning a competitive wage, achieve economic and personal independence, have friends and relationships with people who are not paid to be with them, fully engage and *lead* as citizens of their communities? Are we supporting people to live as we say we believe they can?

The nearly 20 years of litigation due to conditions of poor treatment in our institutions produced needed expansion and improvement in Tennessee's home and community-based services. However, it also inadvertently produced a system and requirements often colored through the lens of an institutional mindset that tend toward paternalism and low expectations, a system that can be administratively burdensome and expensive, and one that, in many cases, has not been fully modernized to meet the expectations and support the full potential of people living with disabilities today.

We want you to know…

Every person, regardless of their level of disability, will receive the supports they need to live safely in the community and to achieve their highest potential.

These proposed amendments mark the next phase of Tennessee's decades long system transformation (and ultimately, *culture* transformation) in supporting people with I/DD in Tennessee and across the country.

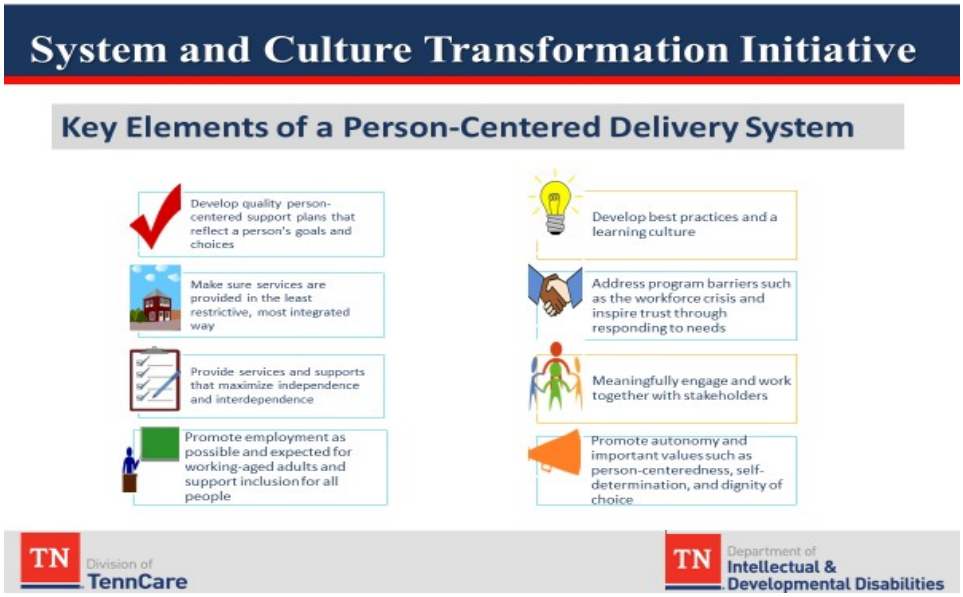
It continues our shared efforts to create a "new and better way," and at the same time affirms our unwavering commitment to continuity and careful transition between two worlds – the "old" and "new" – where no one, regardless of the level of their disability or their need for support, is left out or left behind.

We want you to know…

We are not "starting from scratch." In developing this proposal, we started with feedback received from stakeholders over a period of many years. And we continue to gather more.

It is a transformation that had its beginnings in late 2013 as TennCare and DIDD began gathering input that ultimately informed the design and launch of Employment and Community First CHOICES, a managed LTSS (MLTSS) program specifically designed to align incentives toward supporting competitive, integrated employment and independent community living as the first and preferred goal for people with I/DD. It was then that we began to ask those to whom it most mattered how things could and *should* be different—both as we sought to improve our current programs and to create a new one.

Building on that input, in mid-2016, TennCare and DIDD jointly launched a System Transformation Initiative across Medicaid programs and authorities that serve more than 40,000 people in institutional and home and community based service settings, with the goal of transforming the entire LTSS system to one that is person-centered and that aligns policies, practices, and payments with system values and outcomes.



TennCare and DIDD, in collaboration with a statewide System Transformation Leadership Group (STLG) comprised of self-advocates, family members, advocates, providers, health plan partners, and state leadership, identified key drivers of transformation at the person or individual level, the provider or service delivery level, and the program or system level, recognizing that advancements—especially at the system level—will help to achieve a broader culture transformation when people with disabilities are better supported to enjoy the rights, valued roles, and quality of life that other citizens are afforded. These drivers guided efforts by each agency to advance this work.

As a new Administration launched in 2019, TennCare and DIDD began meeting to emphasize this vision, reflective of input gathered over years, in each agency's multi-year strategic planning process. At the time, there was no talk of integration; the focus remained squarely on how best to advance a person-centered delivery system. The result of these meetings was an agreement on a set of shared strategic objectives to further the transformation effort:

- Embed person-centered thinking, planning and practices and align key requirements and process across Medicaid programs and authorities in order to **create a single, seamless person-centered system of service delivery for people with I/DD**, including: critical incident management, quality assurance and improvement, direct support workforce training and qualifications, provider qualifications and enrollment/credentialing processes, value-based reimbursement approaches aligned with system values and outcomes.
- **Increase the capacity, competency and consistency of the direct support workforce**.
- **Support the independence, integration, and competitive, integrated employment of individuals with I/DD** through the use of effective person-centered planning, enabling technology, and the development of natural supports as evidenced by an increase in the number of working age adults participating in competitive, integrated employment, and the transition of persons supported to less intensive support arrangements based on individualized needs and preferences.
- Partner with TennCare-contracted MCOs to build the statewide capacity and continuum of the behavioral health system to **meet the needs of individuals with I/DD who have co-occurring mental health conditions or behavior support needs in a person-centered way** (moving toward independence and integration to the maximum extent appropriate).
- **Integrate the budgeting process** for programs and services for people with I/DD in order to best meet the needs of all Tennesseans with I/DD and their families.
- **Eliminate the waiting list** of persons with I/DD who are actively seeking to enroll in Medicaid services.

As the first FY 20-21 budget passed in mid-March 2020, it appeared we were well on the way, with funding recommended by the Governor and approved by the General Assembly to advance many of these objectives.

While the budgetary challenges brought on by the COVID-19 public health emergency brought unanticipated challenges (including the loss of previously approved funding to serve 2,000 people from the waiting list and to launch new value-based workforce incentives), it also brought opportunity—to take action that will have significantly greater impact in achieving the vision of true transformation.

With a Concept Paper released in July, TennCare and DIDD proposed to integrate all Medicaid programs and services for individuals with I/DD—including Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID), the Section 1915(c) home- and community-based services (HCBS) waivers, and Employment and Community First CHOICES[1] into the managed care program, under the direct operational leadership, management, and oversight of DIDD.

We want you to know…

This plan to integrate services for people with I/DD into managed care is new; the proposed approach and things we want to accomplish have been in development for years—with our stakeholders.

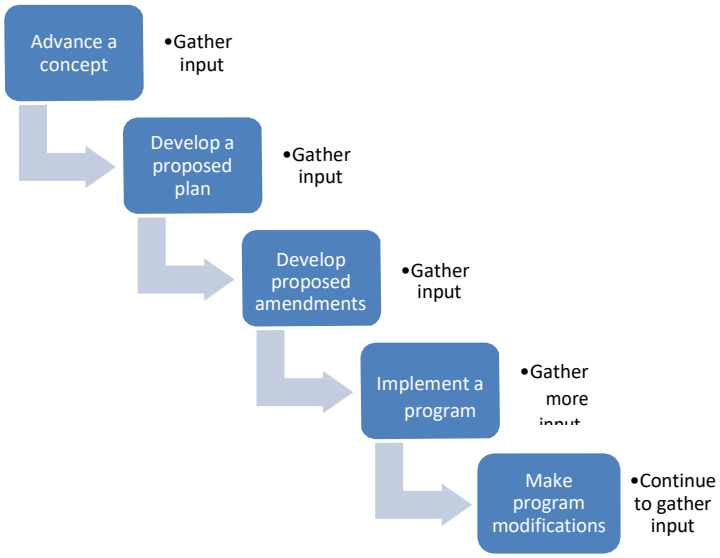
The *Concept Paper* reflected a vision that was both fresh (barely a month old in terms of the proposed integration into managed care) and also seasoned—developed over many years of listening to and partnering with those served in our programs, their families and advocates, and the providers who actually deliver these important services and supports.

Following the announcement and release of the *Concept Paper*, the two agencies partnered to begin engaging with stakeholders to gather additional input that would help to inform a more detailed plan. We immediately scheduled discussions with the provider association--Tennessee Community Organizations (TNCO), the Council on Developmental Disabilities, The Arc of Tennessee, Disability Rights Tennessee, and the Tennessee Disability Coalition. In light of potential risks of in-person meetings, we scheduled webinars open to the broad stakeholder community, turning the Concept **Paper** into a Concept **presentation**, and responding to questions.

We were then asked by stakeholders to develop a more "person and family friendly" version of the materials and to schedule a time just for these groups, where they could more freely ask *their* questions and share *their* thoughts and ideas. We did so and are grateful to the Tennessee Council on Developmental Disabilities for leading the development of those materials, which were presented on multiple occasions. We were also asked to extend the time period for input following those discussions to allow more time for their thoughtful input, which we did—until nearly the end of August. By that time, we had received more than 100 pages of detailed comments online, as well as lengthy letters from many advocacy groups and TNCO.

[1] Employment and Community First CHOICES is already part of the managed care program, but not under the direct operational leadership, management and oversight of DIDD.

At the conclusion of the period, we spent a few weeks analyzing, summarizing, and thoughtfully considering all of the input to inform a more detailed plan: this **Overview of Proposed Amendments and Changes to Integrate and Transform Long-Term Services and Supports (LTSS) for People with Intellectual and Developmental Disabilities (I/DD).**



This is not a "typical" step in the amendment process. This approach-- to advance a concept, gather input, develop a plan, gather input, develop proposed amendments, gather input, implement a program, gather more input, make program modifications, continue to gather input…—is one that has been used for other LTSS initiatives, making sure that those who have the greatest stake in a system are afforded ample opportunity to help shape and reshape the public policy that guides that system forward.

Context of This Document

Typically, a request to modify the TennCare II demonstration would be submitted as an 1115 waiver amendment. However, the current TennCare II demonstration waiver expires on June 30, 2021, and must be renewed. The Centers for Medicare and Medicaid Services has thus advised that rather than submitting this request as an amendment, it should be submitted as part of the renewal of the TennCare II demonstration waiver. The demonstration renewal application must be submitted to CMS by December 31, 2020. In an effort to ensure even more opportunity for public comment, TennCare and DIDD are posting these *"Proposed Amendments to Integrate and Transform Long-Term Services and Supports for People with Intellectual and Developmental Disabilities"* now.

We are listening…

This document is primarily to help stakeholders understand the "bigger picture" in order to inform additional input regarding proposed changes. We will consider all of the input in developing actual draft documents … which will be posted for additional public comment prior to submission to CMS.

In further interest of transparency, we note not only proposed changes to the TennCare II Demonstration that will be sought as part of the renewal of the 1115 demonstration waiver but, also highlight expected changes that will be requested in the 1915(c) HCBS waivers and the Medicaid State Plan via amendments to each respective document. A summary of all of these changes is included in Appendix A.

By including this information, we seek to provide a more complete picture of the proposed changes to the I/DD service delivery system. Even after we review public comments on the proposed changes across Medicaid authorities received in response to this document, additional opportunities for public review and comment will occur as a more formal part of the submission of each request—Amendments to the Section 1915(c) Waivers, Renewal of the TennCare II Demonstration, and the Amendment to the Medicaid State Plan.

Finally, in addition to previewing proposed changes to the Medicaid authorities under which TennCare's LTSS for individuals with I/DD operate, we also provide explanation of how the system is structured today, how it can be different, and we offer detail regarding how changes will be operationalized. While some are beyond the scope of federal authority (and thus will not actually be part of proposed amendments), we share this additional detail in order to further explain how the system will actually work to better support people with I/DD in living the lives they choose.

Overview of Proposal

Key Objectives

At its core, these amendments are about continued system transformation—creating a single, seamless person-centered system of service delivery for people with I/DD that empowers their full citizenship, ultimately achieving culture transformation. System transformation is not a point-in-time event, but rather a process that will occur over time. These amendments provide authority to make changes that we expect will substantially advance our progress toward the ultimate goal over time.

We want you to know…

Implementation will not happen all at once—on July 1, 2021. Changes will occur over time, carefully ensuring continuity and stability.

To be clear, it is a goal **for all**, not for some. In that regard, we will not leave behind those currently enrolled in these programs who have more significant disabilities or who face greater challenge in finding their own unique place in community. The vision of possibility—in employment, in community living—is for one and for all. This includes those waiting for services. Thus, these amendments are also about ensuring equal access to services through the responsible and effective management of limited resources. It is not about taking from some and giving to others, but rather making sure the services and supports provided are uniquely and individually matched to each person's needs, always with eye toward empowering each person to the extent possible to rely less on paid services when appropriate, and to more fully embrace a life of independence and interdependence, a life of self-determination, in community.

New Contract Structure

Under the proposed amendments to integrate and transform programs and services for people with I/DD, all LTSS for individuals with I/DD will be part of the managed care program. This means that for each person receiving Medicaid LTSS (including 1915(c) HCBS waiver and Intermediate Care Facility for Individuals with Intellectual Disabilities or ICF/IID services), their currently assigned Managed Care Organization (MCO)—the entity already charged with administering their physical and behavioral health benefits—will also have a role to play in their LTSS as well. People with I/DD are not being "moved into managed care." They are already in managed care. Rather, their LTSS benefits will now be brought into managed care as well. These LTSS will be administered through the managed care program under the direct operational leadership, management, and oversight of DIDD.

We want you to know…

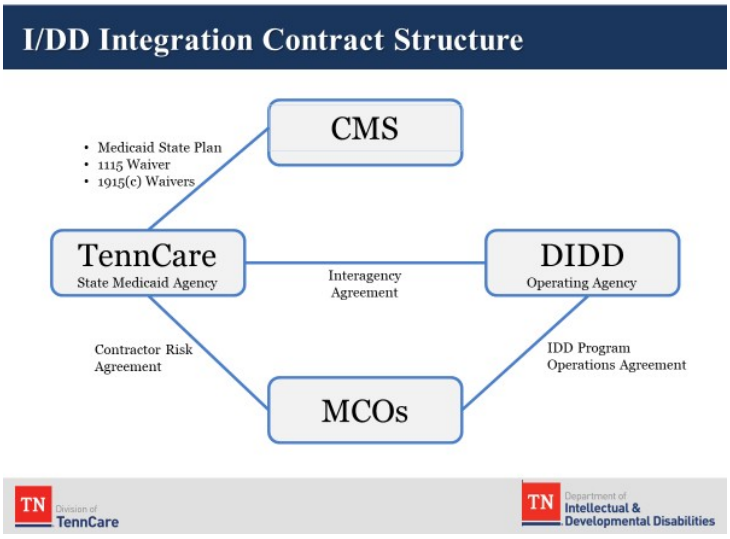
People with I/DD are not being "moved into managed care." They are already in managed care. Rather, their LTSS benefits will be brought into managed care as well. These LTSS will be administered through the managed care program under the direct operational leadership, management, and oversight of DIDD.

Managed care programs have increased exponentially across the country. More and more, these programs are beginning to "carve in" benefits, including LTSS, for people with I/DD. Just the term "managed care" can spark fear among some groups…fear that services will be reduced or denied in the interest of saving money; that managed care organizations will be incentivized to withhold services in order to drive organizational profit; that people with the most significant needs will not have the supports they need to live in the community and will end up institutionalized; that longstanding community providers will be left out of the network, not paid at a level that allows them to sustain service delivery, or caught up in an endless mire of administrative complexities they cannot negotiate; or that the values and principles self-advocates, families, advocacy organizations, and state I/DD agencies have long fought to establish will be lost or at least diminished in favor of efficiency.

TennCare and DIDD seek to demonstrate a managed care approach that works **for** people with disabilities by:

- Preserving, protecting and indeed **strengthening** core system values;
- Aligning incentives in ways that will support the achievement of individual and system goals;
- Bringing to bear all of the tools and capacities that experienced health insurance companies have to coordinate and improve health care and health outcomes especially for those with the most complex and chronic needs and disabilities, based on each person's individualized support needs and plan;
- Reducing administrative burden for providers and helping them develop their capacity to deliver high quality support and produce high quality outcomes and paying for them more for doing so; and
- Providing a direct leadership and oversight role for the state I/DD agency that will help to ensure that the person is always at the center of how supports are delivered.

As the federally designated State Medicaid Agency, TennCare will contract with DIDD to serve as the operational lead agency for all I/DD programs and services. This includes the 1915(c) Waivers, Employment and Community First CHOICES, and ICF/IID services. TennCare will continue to maintain a Contractor Risk Agreement with MCOs (encompassing the broader TennCare program requirements, including physical and behavioral benefits), with DIDD entering into a separate I/DD Program Operations Agreement which will clearly define DIDD's authority in leading the day-to-day management and oversight of the MCO contracts for I/DD benefits.



At the onset, payments to MCOs for LTSS provided to the I/DD population will not be fully risk-based but will include incentives to align with the achievement of individual and program goals (as further described in the value-based reimbursement section below).

We are listening…

- Payments to MCOs for LTSS provided to people with I/DD will **not** be risk-based for now.
- All of the current programs will continue on July 1, 2021.
- No benefits are being eliminated.

Program and Benefit Structure

The vision is a single, seamless person-centered system of service delivery for people with I/DD. However, we recognize that these programs today are quite different.

The integration of Medicaid LTSS programs and services for people with I/DD calls for a careful balance—seeking to advance toward the creation of a single, aligned, person-centered program of support for people with I/DD and their families, while also ensuring stability and continuity of important services and longstanding relationships with providers and direct support staff.

Accordingly, TennCare and DIDD propose to maintain the separate programs for the time being. The system will continue to include Employment and Community First CHOICES, three Section 1915(c) Waivers (the Statewide Waiver, Comprehensive Aggregate Cap Waiver, and Self-Determination Waiver), all operated concurrently under 1915(c) and 1115 Waiver authority to provide additional flexibility; and ICF/IID services.

TennCare and DIDD also propose largely maintaining the current benefit structure in each of the applicable programs and beginning to evolve these benefits in a manner that aligns with the intended goals of the new integrated and aligned system—leveraging effective person-centered planning, Employment Informed Choice,[2] enabling technology, telehealth, value-based payment, and other approaches to advance the achievement of person-centered goals, including employment, independence, and integrated community living.

[2] As currently applied in Employment and Community First CHOICES, Employment Informed Choice is the process the MCOs must complete for working age members (ages 16 to 62) who are eligible for, and want to receive, Community Integration Support Services and/or Independent Living Skills Training services when the member is not engaged in or pursuing integrated employment. The Employment Informed Choice process includes, but is not limited to, an orientation to employment, self-employment, employment supports and work incentives provided by the member's support coordinator; the authorization and completion of Exploration services in order to experience various employment settings that are aligned with the member's interests, aptitudes, experiences and/or skills and ensure an informed choice regarding employment; and signed acknowledgment from the member/representative if the member elects not to pursue employment. Roughly 70% of people who complete the Employment Informed Choice process elect to pursue employment.

Assessing potential for the use of enabling technology as an integral part of the person centered planning process and ensuring access to enabling technology as a distinct benefit will be important across all of these programs, as will ensuring that reimbursement for services such as residential, personal assistance, individual employment supports, etc. includes technology-based support rates, as appropriate.

We want you to know…

Across the programs, you will see a focus on identifying opportunities where technology can empower each person to have greater control and independence in their own life—whether or not it impacts their need for paid support. This does not mean people "have to" use technology; rather they have an **opportunity** to understand how it can improve their lives.

Consumer Direction

Based on input, consumer (or self) direction will be available in each of the 1915(c) waivers for services like Personal Assistance, Respite, and Community Transportation.

Therapy, Behavior and Nutrition Services

As it relates to occupational therapy (OT), physical therapy (PT), speech, behavior services and nutrition services, we intend to move toward a consultative model similar to that used in Employment and Community First CHOICES, leveraging licensed 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. This could be accomplished in a number of different ways—by redefining the scope of these services as part of 1915(c) amendments and/or by leveraging telehealth options and/or value-based payment to drive toward preferred outcomes. We seek input regarding these and other potential strategies. In any option, a plan for fading direct services when appropriate is an essential component.

Nursing Services

As the population ages and people with disabilities are living longer, the need for nursing care—in hospitals, nursing homes, and in people's homes and other community-based settings—is outpacing the supply of nursing services. Like many states, Tennessee faces a shortfall of nurses. However, in light of the gap between supply and demand, Tennessee has lagged behind the vast majority of other states in utilizing various flexibilities to drive a more efficient way to meet skilled needs in the community.

We want you to know…

Therapies, nutrition services, and nursing services will continue to be covered benefits. However, we will begin to evolve how those services are provided in order to increase both the efficacy and efficiency of service delivery, while ensuring that each person's needs are safely met.

Highly skilled health care professionals are often required to perform routine health maintenance tasks that are frequently performed by unskilled family caregivers—at a high cost to the Medicaid program and to the system as a whole in terms of utilizing limited nursing resources.

As an example, in the HCBS waivers, a person may receive significant hours of skilled nursing services or be admitted to Medical Residential Services when the only needed nursing task is a periodic finger stick to check blood sugar or the administration of nebulizer treatments or oxygen—tasks that are easily taught and performed by unskilled workers (and at a significantly lower cost), freeing up limited nursing capacity to meet more complex skilled needs.

Requiring that such tasks are performed only by a licensed nurse drives up the cost of providing care in the community, forces more people into expensive institutional placements, and limits the ability to cost-effectively serve more people in HCBS settings. As Tennessee continues to move toward serving more people in community settings, we must restructure the way nursing care is delivered and utilize registered nurses more in their teaching and consulting roles.

It is critical that we begin to move forward with strategies to teach, train, and support paid (or when available and willing, unpaid) caregivers to perform those more routine (i.e., non-complex) health care tasks, potentially coupled with remote support (or telehealth consultation on an as needed basis). This would increase access to community living, remove potential barriers to transition from institutions, and leverage limited skilled nursing resources to practice at the top of the license, performing the most complex skilled tasks directly, while ensuring that individuals with skilled nursing needs can continue to have their needs safely met in the community. Research has borne out that quality of care is not compromised by allowing these flexibilities, and in some cases, is improved. This could also be accomplished in a number of different ways—by changes to the scope of the benefit and/or through a modified payment structure, with significantly higher payment for services that help to expand capacity to deliver needed care. We seek input regarding these and other potential strategies.

Residential and Day Services

In order to better align reimbursement with individualized needs, we plan to combine residential and most day services into a single benefit entitled – Community-Based Living Supports (CBLS). This will help to ensure that a person's day is not artificially delineated between the six hours of support payment derived from the receipt of "Day" services—typically outside the home, and the remaining hours derived from the residential payment—typically inside the home, an approach that hearkens back to the "programs" of years ago rather than the individualized supports people want and expect to receive today. The provider will be responsible for delivering the supports each person needs to achieve their identified outcomes, participate in the activities of his/her choosing, at the time of his/her choosing, and in the setting of his/her choosing, so long as compliance with the HCBS Settings Rule is maintained. To be clear, all day services currently available to persons enrolled in these waivers will continue to be available, and providers will be paid to deliver both types of assistance. Payments for these services will be combined with payments for traditional "residential" services into a more modernized and flexible individualized benefit driven by the needs and preferences of the person.

We are listening…

All of the current residential and day service options will continue to be available. We are combining the services and the payment for these services to provide greater flexibility with regard to how people spend their day.

In order to support persons in pursuing and achieving competitive integrated employment, employment services, including Job Coach, will continue to be reimbursed separately, and will include technology-based support options.

ICF/IID Services

As noted in the introduction, in the last decade, Tennessee has closed each of its three remaining congregate institutions for people with intellectual disabilities. One of the individuals transitioning to the community and electing to participate in Tennessee's successful Money Follows the Person Rebalancing Demonstration was the longest institutionalized person under the program—finally attaining community living following a period of living in an institution for more than sixty (60) years.

While abiding by freedom of choice as currently described in the federal regulation resulted in a number of smaller 4-bed ICF/IID "homes" being established across the state to serve transitioning residents (public as well as privately operated facilities), the overall growth in ICF/IID services in Tennessee has remained low—due in part to a statutory cap on new Certificates of Need for private ICF/IID facilities. Currently there are 804 private beds (including small 4-bed as well as larger facilities established prior to the 4-bed limit effective June 2000), five state-owned but privately operated 4-bed ICF/IID "homes" (20 beds), 37 publicly owned and operated 4-bed ICF/IID "homes" located across the state (148 total beds), and 12 Day

One public ICF/IID beds at the Harold Jordan Center. In total, these nearly 1,000 beds represent roughly 10 percent of persons with I/DD receiving LTSS, and more than 20% of total LTSS expenditures for people with I/DD. While DIDD maintains well-defined admission criteria and processes for the public facilities, the threshold for ICF/IID medical (level of care) eligibility is very low—an intellectual disability combined with a single activities of daily living (ADL) deficiency. The lack of other effective means of oversight regarding private ICF/IID admission results in people being placed in ICFs/IID that could be served in more integrated community settings, and at a lower cost.

TennCare and DIDD explored the possibility of changing the ICF/IID level of care criteria, but based on input, did not want to consider changes that could also negatively impact eligibility for the 1915(c) waivers (which are tied under the federal regulation to the comparable level of institutional care).[3]

In order to ensure continuity for persons currently receiving ICF/IID services while directing new enrollment (to the maximum extent possible and appropriate) to more integrated and cost-effective HCBS settings, we propose the following:

- We will continue to cover ICF/IID services but move the benefit from the Medicaid State Plan to the 1115 demonstration. This will assure continuity of care for individuals currently receiving these services.
- Beginning on July 1, 2021, in addition to meeting ICF/IID level of care criteria, new admissions to an ICF/IID will be limited to persons with such significant co-occurring behavioral challenges or complex medical needs that the person cannot be immediately served in a more integrated setting, and only for the limited period of time that is necessary to complete a comprehensive assessment of their community living needs, develop a comprehensive transition plan, identify a community provider and seamlessly transition to a more integrated community setting.

We want you to know…

ICF/IID services will continue to be covered under the 1115 waiver, offering greater flexibility to align the provision of these services under the Medicaid program with the requirements of the ADA. By changing how the benefit is utilized, we can leverage these services for shorter term placements that will provide for transition to more integrated settings as appropriate.

[3] TennCare will request waiver and expenditure authority to expand the ECF Working Disabled demonstration group to include individuals enrolled in a Section 1915(c) waiver as of July 1, 2021, and to expand Medicaid eligibility categories covered under the 1915(c) waivers to include the ECF Working Disabled demonstration group. This will allow individuals enrolled in a 1915(c) waiver who are working to have earned income up to 250% of the FPL excluded when considering their continued eligibility for Medicaid and for HCBS.

These determinations will be made by an Interagency Review Committee led by DIDD and will include TennCare and MCO clinical and program leadership. Further, before any such admission could be approved, the person would participate in an Community Informed Choice Process conducted by an entity other than an ICF/IID provider to ensure that s/he fully understands the full array of community-based options available to meet his/her needs, and having been fully informed, affirmatively chooses the institutional placement. This will better align the provision of these services with federal law that did not exist when the benefit was first established—namely, the Americans with Disabilities Act.

- Beginning no earlier than July 1, 2022, TennCare and DIDD, working with MCOs, will commence an individualized review process in order to identify individuals receiving ICF/IID services as of July 1, 2021, who can be supported in more integrated community settings and following a Community Informed Choice process, elect to do so, and work with each such person identified to complete an individualized comprehensive assessment of their community living needs, develop a comprehensive transition plan, identify a community provider and seamlessly transition to a more integrated community setting.

- TennCare and DIDD will work with ICF/IID providers who desire to repurpose "bed" capacity primarily to meet the transitional stabilization, assessment and planning needs of those with significant co-occurring behavioral health conditions or complex behavior support challenges, as well as those with complex medical needs.

- The reimbursement methodology for ICFs/IID will be restructured to reflect both the higher acuity of individuals receiving these services, and to reflect value-based incentives for specific outcomes that lead to integrated community living.

Program Expenditure Caps

A program expenditure cap functions as a limit on the total cost of HCBS a person can receive in the home or community setting while enrolled in the applicable HCBS program.

Based on input received, DIDD and TennCare intend to maintain the existing expenditure cap structures currently applicable in each program. No changes are proposed.

Support Coordination

High quality Support Coordination is the cornerstone of effective person-centered planning. Today, there are multiple different support coordination (i.e., case management) models in Tennessee's I/DD delivery system. Based on input received, TennCare and DIDD plan to keep all the current models to support coordination within their existing programs.

- Individuals enrolled in the Statewide and CAC waivers will keep their Independent Support Coordinator (ISC).
- Individuals enrolled in the Self-Determination waiver will keep their DIDD case manager.
- Individuals enrolled in Employment and Community First CHOICES will keep their MCO Support Coordinator.

The efficacy of these models can then be measured by whether they are successful in helping persons supported in making person-centered life choices, utilizing enabling technology to increase their independence, and in achieving employment and community living goals. We can use that information to drive future decisions regarding how best to deliver support coordination in the integrated system.

Payment for ISC agencies would ultimately be driven in part by whether outcomes are in fact achieved. Likewise, we will identify ways to align administrative payments to MCOs for Support Coordination on the same key metrics.

This comparison would be part of the Evaluation Design (required by CMS as part of the 1115 demonstration) for the integrated system, reviewed by an external entity, and shared with other states to help inform future MLTSS design decisions.

Assessing the Level of Supports Needed

An effective person-centered planning process begins with understanding each person—who they are, what matters to them, and what they want to achieve, as well as the supports they need to be successful in achieving those goals and living the life they choose. Essential to this process is an objective and uniform way to assess each person's supports needs. The Supports Intensity Scale® (SIS) is a normed and validated instrument created by researchers working with the American Association on Intellectual and Developmental Disabilities (AAIDD) which measures each individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS was specifically designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals. The SIS is already used in well over 20 states, including Tennessee.

In addition to the SIS, TennCare and DIDD plan to use Tennessee's Person-Centered Enabling Technology Plan Questionnaire. The Enabling Technology Plan Questionnaire delves deeper into each person's support needs, with an eye toward potential opportunities where technology may help to increase the person's independence in or across environments, including home, travel, community, work and volunteering.

Person-Centered Support Plans (PCSP)

As with other aspects of the new integrated system, the goal as it relates to person-centered planning will ultimately be to achieve alignment across programs. This includes a single PCSP format. TennCare has recently gathered input from providers and other stakeholders and partnered with MCOs to redesign the current PCSP template for Employment and Community First CHOICES, making changes intended to support improved development of individualized measurable outcomes and to track progress toward their achievement. TennCare and DIDD have already begun a process of cross-walking the documents used in each of the existing programs to identify opportunities for alignment. If this cannot be accomplished by July 1, 2021, MCOs will continue to use the newly improved PCSP template for Employment and Community First CHOICES, and DIDD will use the existing ISP template for 1915(c) waivers until such time that a single aligned template can be accomplished.

Even more critical than the template, however, will be alignment of expectations regarding person-centered thinking and planning processes, including quality expectations regarding the planning process and the PCSPs, the usefulness of PCSPs to providers relying on them to support people with IDD, and the individual outcomes that derive from their effective implementation.

DIDD will lead a coordinated approach to quality monitoring and improvement for person-centered plans and planning processes. DIDD will review a sample of each MCO and ISC Agency PCSPs for purposes of quality monitoring and improvement, and for purposes of the evaluation design (described above), and work with each entity to help drive quality improvement. TennCare will conduct this review for DIDD case managers, using the same tool and process.

While MCOs will generally have utilization management authority over PCSPs (meaning review and approval of services), we plan to establish contractual threshold requirements that would trigger a DIDD review/approval as well—primarily focused on ensuring that service denials or reductions are appropriate and that supports are sufficient to meet individual needs and support the achievement of personal goals. These could be based on a threshold amount or percentage—with the specific methodology to be determined in the I/DD Program Operations Agreement. We welcome input regarding these criteria or processes.

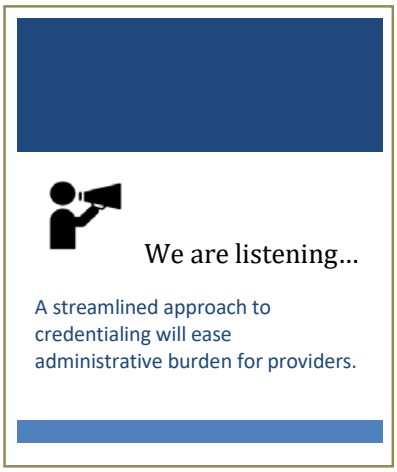
We are listening…

Based on input, DIDD will directly oversee MCO review of person-centered support plans, including service denials or reductions.

Network Development and Management

Today, there are also multiple different provider networks and approaches to provider enrollment/credentialing/re-credentialing in the I/DD delivery system. Many providers complete four (4) unique enrollment and credentialing processes—five (5) if they also provide ICF/IID services, often requiring much of the same information.

The integration of Medicaid programs and services again provides a unique opportunity to explore a new, streamlined approach to provider credentialing—one that seeks to minimize administrative burden on providers, health plans, and the state, and which seeks to recognize and value those providers who demonstrate the greatest commitment and success in terms of supporting persons with I/DD to achieve desired outcomes.



In this proposed new streamlined approach, DIDD would serve in a "credentialing" role for all HCBS provider types across the I/DD delivery system (with the potential exception of Adult Dental Services). All currently qualified and contracted providers in the 1915(c) waivers (including ISC agencies), currently credentialed and contracted providers in Employment and Community First CHOICES, and certified ICFs/IID would be "deemed" by DIDD as credentialed for participation in the integrated system.

New providers would be credentialed by DIDD using standards established in partnership with DIDD and MCOs, with input from I/DD stakeholders. These would be focused around the "Pillars of Transformation" (see image at left) that will inform values-based provider reimbursement and ultimately drive delivery system transformation.

Under the proposed new credentialing approach, MCOs would be expected to abide by the "deemed" status, and not establish additional requirements or credentialing processes or standards that would again result in multiple different processes.

Likewise, providers would be periodically re-credentialed by DIDD using standards established in partnership with DIDD and MCOs.

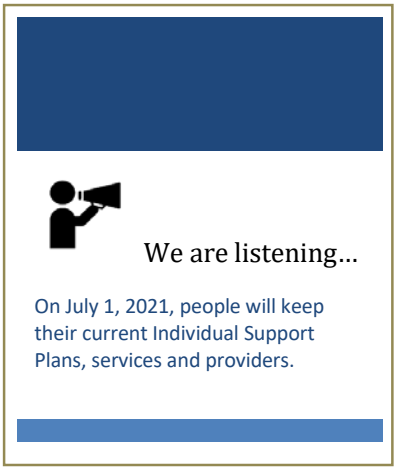
Consistent with the principles of managed care, to ensure that MCOs maintain flexibility to drive quality performance and outcomes, except for continuity of care (described below) and with the potential exception of ISC agencies at least during the evaluation phase (described above), MCOs would not be obligated to contract with all providers "deemed" as credentialed, but could select from "deemed" providers using a set of person-centered "preferred" contracting standards similar to those developed for Employment and Community First CHOICES, but updated based on learning to date and goals of the new integrated system. MCOs would be required to demonstrate network adequacy. This means that a provider could be "deemed" by DIDD to meet credentialing standards, but not selected by any MCO for network participation. This will be an important part of the network management process—ensuring that potential providers fully understand how contracting decisions will be made.

Initially, these standards would function as "preferred standards." MCOs would be expected to take the "preferred standards" under consideration in developing their networks, and network monitoring would review whether in fact MCO networks demonstrate compliance with this expectation. Over time, we expect that the standards would evolve to "required standards." After a reasonable period (at least 12 months), providers would be **required** to meet certain standards to continue participation in the program, with additional quality performance standards becoming required over time, while ensuring sufficient capacity to offer choice of providers and timely delivery of services.

While MCOs would generally have authority to build their I/DD networks and would not be obligated to contract with any particular I/DD provider, DIDD would have the authority to ensure an MCO contract with a highly preferred I/DD provider (based on contracting standards) to address identified network gaps—related to the ability to deliver needed services without gaps in care or to address quality (including quality outcome) concerns. In these instances, an MCO would be expected to either contract with an identified provider, or to contract with an alternative provider that is equally preferred and able to fill the identified gap.

Continuity of Care

Notwithstanding the language above, except for significant quality or compliance concerns, 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.



We are listening…

Based on input from providers, we are exploring opportunities for a streamlined authorization, billing and payment system.

Beginning July 1, 2021, provider authorization and billing processes **will not change—**for HCBS and ICF/IID providers. Payments will be made to providers by MCOs.

Authorizations, Billing and Payment

Today, there are also multiple different provider authorization, billing and payment processes and systems in the I/DD delivery system. Many providers complete four (4) unique billing processes—five (5) if they also provide ICF/IID services.

The integration of Medicaid programs and services provides a unique opportunity to explore a potential new, streamlined approach to provider authorizations, billing and payment—one that seeks to minimize administrative burden on providers, health plans, and the state, and which seeks to ensure that providers have timely access to authorizations, and a consistent user-friendly billing process. It would also ensure continuity across procurement cycles.

This is best achieved through a consolidated system. The PCSP would be developed in or uploaded into this system. This would allow for DIDD and TennCare to have timely access to all plans of care—for purposes of quality monitoring, reportable event management, overall program review and trending, etc., and perhaps also for purposes of broader care coordination (with PCPs, etc.) PCSP data would drive authorizations that could also flow from the consolidated system. This would provide for ongoing tracking to ensure that authorizations are in fact occurring timely and without gaps. Authorized services would also be used to generate billing templates for providers, indicating each of the services they were authorized to provide for each member, and allowing them to indicate which of the services were in fact provided. This information would be used to generate claims files to the MCOs for processing and payment.

Such a system would ensure a consistent, timely and efficient authorization and billing process for I/DD providers. It would also provide DIDD and TennCare better access to comprehensive program data that could help to drive quality improvement.

While we are exploring potential options to determine if such a system could be purchased or developed, we recognize that such a consolidated system is likely not possible by July 1, 2021. However, due to design decisions related to support coordination processes (described above), DIDD can continue to leverage existing systems and billing processes. Upon receipt of the claims files, TennCare will separate the files by MCO, and forward for processing and payment. ICF/IID providers will continue to utilize the TennCare billing portal, with TennCare directing the claims to the MCOs.

TennCare and DIDD are working together to explore the most efficient and timely options to streamline and consolidate functions across programs going forward. We welcome input regarding these processes.

Value-Based Reimbursement

One of the most important drivers of delivery system transformation is changes in the way Medicaid payments are made. Thus, a key component of the integrated system will be the implementation of value-based reimbursement for "core" services—primarily residential, day, and personal assistance—to align payment with the achievement of individual and system outcomes.

The successful design and implementation of such an important driver will take time and depend on the active engagement of providers and others. We are establishing such a group— of *"Partners in Innovation"*— that can help to inform this and other system components described in this document. The value-based reimbursement approach ultimately developed will be implemented in an incremental way to ensure the stability of the network, while also building capacity to demonstrate the delivery of improved outcomes for persons supported.

We are listening….

A values-based reimbursement approach is still in its early development and will likely not be ready by July 1, 2021.

Based on recommendations from the Systems Transformation Leadership Group to we are sharing a proposed framework in order to gather additional input.

Stakeholders will have input, and changes will occur incrementally ensure stability for persons supported and providers.

We propose that payments for traditional "day" services would be combined with payments for traditional "residential" services into new payment rates for a more modernized and flexible individualized benefit driven by the needs and preferences of the person. (Employment services would continue to be reimbursed separately at the current levels.)

Based on longstanding feedback from providers, payment for services would be de-linked from staffing ratios. They would also be de-linked from the number of people living in a home, allowing greater flexibility with regard to how best to meet each person's individualized needs and preferences.

Payment for the newly combined Community-Based Living Supports benefit would be based on the person's Level of Support, with flexibility across the types of supports that can be leveraged to meet those needs, (including technology-based supports and natural supports as well as paid assistance), and documentation regarding the type of supports to ensure transparency for measuring payments against hours of paid support provided and for purposes of measuring success in achieving individual and program goals. **This will ensure that people who continue to need 24 hours a day of paid assistance will receive such support,** but without an expectation that everyone will have 24 hours a day of paid support when it is not needed, or when other support options (enabling technology, natural supports, etc.) would provide greater freedom and independence. Payment mechanisms such as special needs adjustments would be replaced with reimbursement for additional assistance actually needed and provided, rather than paying for the availability of such assistance "just in case."

Funds from the simplification of rate tiers and the move to paying for additional assistance when actually provided could be repurposed to create an incentive structure that will reward providers for actions taken to build their capacity to deliver high quality outcomes and ultimately for the outcomes themselves. This would help to drive the system forward toward the vision of person-centered transformation.

Based on the work of the Systems Transformation Leadership Group, we propose that measurement domains will be aligned with the Pillars of Transformation described in the Network Development section above. By aligning both provider expectations and provider performance around common expectations directly linked to program goals, we are setting providers on a course for individual and program success.

Person-Centered Thinking, Planning and Supports, Technology First, Employment First, Independence and Workforce measurement domains would include both capacity-building and outcome metrics. Capacity-building is intended to support providers in investing in their own organizations in ways that will better position them for success.

- For example, achieving Basic Assurance© certification status, becoming a Person-Centered Organization, earning CQL accreditation in person-centered supports and the ultimate accreditation status "With Distinction" create a pathway toward greater expertise in the delivery of high quality, person-centered supports. Individual outcome measures can then assess the direct impact these capacities are having on persons supported by the agency, with incentives based both on organizational (capacity-building) achievements as well as individual outcomes.
- The achievement of professional level certification through APSE or other approved entities by employment staff will better position those staff and the agency to achieve a higher percentage of persons supported working in competitive, integrated employment; increased independence of those individuals on the job (paid supports as a percentage of hours worked and individuals achieving success with only stabilization and monitoring or technology-enhanced assistance); and in upward mobility as measured by increases in hours worked, hourly wage and access to employee benefits—all taking into account individuals' LOS needs.
- An agency's attainment of Technology First Organization Certification (ultimately, With Distinction), employing Tech Champions with Enabling Technology Specialist Certificates, and the percentage of DSPs with Enabling Technology credentials fosters a culture within the organization that leads to more people using enabling technology to gain control and independence—in some instances, reducing their reliance on paid supports.

In each of these areas, we would seek to establish and incentivize measures of agency capacity and agency performance which ultimately lead to improved outcomes and better lives for persons supported.

As with Support Coordination, incentives will also be reflected in administrative payments to MCOs, to encourage the development of networks that are best equipped and able to demonstrate person-centered outcomes.

Summary

The proposal outlined and described in this document and the goals we expect it will help to achieve are aspirational and transformational. Implementation will not be instantaneous. Rather, creating a single, seamless person-centered system of service delivery for people with I/DD that empowers their full citizenship is a process that will occur over time.

While it is not possible or responsible to include details on every possible scenario, circumstance or future decision that may be related to the proposal, we will be thoughtful at each step, listening to stakeholders, and building on lessons learned. Most importantly, we will continue to be guided by an unwavering belief that people with disabilities deserve nothing less than the opportunity to live their best lives as full citizens in community and that *every* aspect of *all of our lives*—our families, neighborhoods, workplaces and communities—will be better because of it.

Appendix A

Summary of Proposed Amendments by Authority

Appendix A: Summary of Proposed Amendments by Authority

1115 Demonstration	***1915(c) HCBS Waivers***	***Medicaid State Plan***
Waiver and expenditure authority for the integration of 1915(c) waivers and ICF/IID services into managed care	Include the ECF Working Disabled demonstration group as a Medicaid eligibility category in the waivers—allowing people who are employed to maintain TennCare and waiver benefits	ICF-IID services no longer covered (under the State Plan—coverage moved to 1115 demonstration)
Waiver and expenditure authority for continuation of coverage for current ICF/IID services and new eligibility criteria and informed choice requirement for new ICF/IID admissions (aligned with the ADA)	With ECF Group 8 and newly defined transitional ICF/IID benefit, new enrollment into the CAC waiver also closed	
Waiver and expenditure authority to include people enrolled in a Section 1915(c) waiver in the ECF Working Disabled demonstration group—allowing those who are employed to maintain TennCare and waiver benefits	Person-centered updates in Support Coordination processes and expectations, including Employment Informed Choice process	
Waiver and expenditure authority to add Enabling Technology as a distinct benefit	Add consumer directed options for Statewide and CAC Waivers	
Modifications to criteria for enrollment into TennCare Select to maintain people with I/DD enrolled in SelectCommunity as of 7/1/21	Add Enabling Technology as a distinct benefit	
	Adjustments in therapy, behavior, nutrition and nursing services to maximize efficacy and efficiency	
	Combine residential and most day services into a combined Community-Based Living Supports benefit	
	Values-based changes in reimbursement methodology and expenditure projections for residential and day services	