Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
This is a renewal application for waiver #0128, currently titled the Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled. Tennessee proposes, effective January 1, 2015, to call this waiver the Statewide Home and Community Based Services (or "Statewide") waiver.

In addition to the renewal of this waiver with a new name, amendments encompassed within the renewal application intend to:

1) Modify service definitions and other applicable waiver sections in order to ensure compliance with the Final Rule released by the Centers for Medicare and Medicaid Services (CMS) on HCBS Setting and Person Centered Planning requirements, and to clarify Family Model Residential Services as it relates to compliance with the Department of Labor's Final Rule pertaining to the Fair Labor Standards Act. Tennessee believes it is critical that the objectives of the HCBS Setting and Person-Centered Planning rule are embedded within waiver service definitions and waiver processes in order to appropriately set expectations for all HCBS providers and to support and indeed, require, the kind of culture shift necessary for these objectives to be realized in the lives of individuals receiving support.

2) Modify the Quality Management Strategy in order to reflect CMS changes to waiver Quality Monitoring assurances and sub-assurances, including adding, modifying, or deleting specific performance measures in the waiver application. (The State will continue to monitor performance and assure compliance with waiver requirements, where applicable and/or deemed important.) Changes related to annual reporting, per the CMS Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, released in March 2014, are incorporated throughout. Tennessee would also like to propose to consolidate reporting across the state's three 1915(c) waivers (0128, 0427, 0357)for the Qualified Providers assurance area, per the option offered in the Modifications stating, "..when waivers are managed and monitored similarly, it is expected that discovery and improvement activities would be the same, and that the state will achieve some administrative efficiencies by consolidating quality improvement activities. In addition, this holistic measure will ensure that the system for the waivers is responsive to the needs of all individuals served. CMS may accept a consolidated evidence report for multiple waivers when they meet certain conditions" (page 5 of the guidance document, (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/3-CMCS-quality-memo-narrative.pdf). The reason Tennessee proposes to consolidate reporting for the QP assurance is because our provider network services across all three waivers. Therefore, when there are findings in the QP assurance area, they are applicable (thus, the same compliance rates) across all three waivers. We believe that it is still valuable to measure performance separately across the 3 waivers for the other assurance areas because there may be important variances and will thus continue reporting performance for the state's three 1915(c)

waivers (0128, 0427, 0357) separately in all assurance areas except for the Qualified Provider (QP) assurance.

3) Add Semi-Independent Living as a service and incorporate additional flexibilities and improvements into certain service definitions as recommended by stakeholders through an extensive stakeholder input process. Planned modifications include allowing people receiving different kinds of Medicaid-reimbursed HCBS—primarily residential services—to live together in the same homes, offering more choice and autonomy in living arrangements; allowing a single Personal Assistant or Nurse to provide services to more than one individual at the same time so long as the individuals' needs can be safely met; clarification regarding the provision of non-nursing assistance by a licensed nurse when nursing services are authorized for skilled nursing needs; and flexibility in the hours that Employment and Day Services are provided in order to support goals specified in the person-centered individual support plan.

4) Implement an individual cost neutrality cap based on the average cost of private ICF/IID services. In order to minimize the potential for disruption in services for Statewide waiver participants, individuals currently enrolled in the Statewide Waiver identified by the state as receiving services in excess of the new individual cost cap will transition to the Arlington (renamed "CAC") Waiver (#0357), which will continue to have an aggregate cost cap. A decrease in the number of unduplicated participants will be requested to accommodate these changes. This will be offset by an increase in the number of unduplicated participants who will be newly enrolled into the waiver upon its renewal.

Appendix J of the renewal application reflects revised cost neutrality projections based on the changes identified above.

These changes are part of a more comprehensive restructure of the service delivery system in Tennessee that will allow Tennessee to provide services to individuals with intellectual disabilities more cost-effectively, and to ultimately be able to serve more people with intellectual disabilities (ID), as well as people with other developmental disabilities (DD), as set forth in a Concept Paper available at http://tn.gov/tenncare/forms/ConceptPaper.pdf.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Tennessee** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Statewide Home and Community Based Services (or "Statewide") waiver

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: TN.0128
Waiver Number:TN.0128.R05.00
Draft ID: TN.014.05.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

01/01/15

Approved Effective Date: 01/01/15

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

- ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

[ ] **Nursing Facility**

Select applicable level of care

- ( ) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
- ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

[x] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
a. Meet TennCare ICF/IID level of care criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PreAdmission Evaluation approved by TennCare;
b. Have been assessed and found to:
i. Have an intellectual disability manifested before eighteen (18) years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); or,
ii. Have a developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in an intellectual disability and be a child five (5) years of age or younger.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- (•) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

  Specify the §1915(b) authorities under which this program operates *(check each that applies):*
  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Statewide Home and Community Based Services Waiver serves adults with intellectual disabilities and children under age six with developmental delay who qualify for and, absent the provision of services provided under the Statewide Waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The Statewide Waiver offers a continuum of services that are selected by each person supported pursuant to a person-centered planning process and support each person's independence and full integration into the community, including opportunities to seek employment and work in competitive integrated settings and engage in community life. Services are delivered in a manner which ensures each individual's rights of privacy, dignity, respect and freedom from coercion and restraint; optimizes individual initiative, autonomy, and independence in making life choices; and are delivered in a manner that 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 Individual Support Plan.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who 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. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Public input processes commenced in December 2013 with meetings including advocacy groups representing individuals with I/DD and their families, as well as HCBS provider groups. For each subsequent phase of the process, we notified providers, including case management providers, and asked them to share information with people they

serve and to ensure they understood how to submit comment. We did the same with advocacy groups who work closely with consumers and family members. Beginning in January 2014, data was gathered from consumers, family members, and providers via statewide Community Meetings. An online survey afforded consumers and family members who were unable to participate in Community Meetings an alternative mechanism to provide input. Additional written comments and follow-up recommendations were received by TennCare after the conclusion of the Community Meetings and online survey processes.

A comprehensive Stakeholder Input Summary is available at:
http://tn.gov/tenncare/forms/ID_DDStakeholderInputSummary.pdf.

On May 30, 2014, based on the input received, the State posted for public review and input a Concept Paper (available at http://tn.gov/tenncare/forms/ConceptPaper.pdf), summarizing proposed changes to the State of Tennessee's Section 1915(c)HCBS waivers.

The State again jointly hosted regional community meetings in order to present the Concept Paper to stakeholders, respond to questions, and gather stakeholder feedback. Participants were encouraged to submit written comments prior to leaving. Attendees were also advised of the online survey as an alternative way to submit comments and strongly encouraged to use 1 of the methods to help inform future program changes.

Immediately following the community meetings and based on additional feedback, TennCare worked with the Tennessee Council on Developmental Disabilities to develop easier-to-understand summaries of the Concept Paper for two target groups: individuals receiving waiver services and their families/conservators, and individuals needing and waiting to receive services and their families/conservators. These documents are available at http://tn.gov/tenncare/forms/ConceptPaperSummaryCurrentWaiver.pdf and http://tn.gov/tenncare/forms/ConceptPaperSummaryWaitingList.pdf. TennCare disseminated these summaries to each of the advocacy and provider groups identified above, and requested their assistance in distributing the materials to consumers, family members, and conservators.

A summary of input received on the Concept Paper is available at
http://tn.gov/tenncare/forms/ConceptPaperStakeholderInputSummary.pdf.

Upon review and consideration of this input, the State posted on July 31, 2014 for public review and comment, draft waiver renewal applications. Written comments were received directly through the TennCare website or submitted to the State and reviewed in order to inform the final waiver renewal application. Waiver service definitions were revised to provide additional flexibility that will allow people receiving different kinds of HCBS—primarily residential services—to live together in the same homes, allow a single Personal Assistant or Nurse to provide services to more than one individual at the same time so long as the individuals' needs can be safely met, and to provide clarification regarding the provision of non-nursing assistance by a licensed nurse when nursing services are authorized for skilled nursing needs.

Additional comments were sent by HCBS providers, independent support coordinators, advocates and family members of individuals with ID. Comments were submitted in several ways, including online, direct emails or letters, and face to face meetings. All comments were reviewed in order to inform the final waiver application submitted to CMS.

Approximately 30 commenters submitted feedback, with many submitted on behalf of multiple stakeholders. For example, several comments were submitted by an association representing more than 40 providers in Tennessee. Formal stakeholder groups such as "TennesseeWorks," a collaboration of stakeholders led by Vanderbilt University's Kennedy Center, formed workgroups to provide response.

A number of technical edits or changes were made in response to comments, for example, changing "MR" to "ID", "service recipient" to "person supported", and "plan of care" to "Individual Support Plan (ISP)"; clarifying "year" or "waiver year" as "calendar year", "per quarter" as "once every 3 months", and "days" as "business" or "calendar days".

Some recommendations were not adopted because they conflicted with other recommendations or with the federal person-centered planning and HCBS settings rule. In some cases, we determined that comments were best addressed outside the Waiver renewal process through ongoing stakeholder discussions.

The majority of comments submitted were related to Service Definitions in Appendix C and submitted by providers. The most significant change based on these comments was the addition of Semi-Independent Living Services (which had previously been available only in the Self-Determination waiver #0427). The 8 comments in Appendix D focused on federal person-centered planning requirements, e.g., all providers responsible for implementing the plan must sign the document, and were addressed through ongoing education processes. Most comments in other appendices did not make specific recommendations for changes or sought clarification about waiver language that did not result in further changes.

As changes were made, each revised version of the waiver application was posted online. Continuing conversations with stakeholders following submission of the renewal applications resulted in additional changes made during the RAI process, including adjustments to the Supported Living service definition and language pertaining to reimbursement of Day Services to address concerns that were raised.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal

Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Killingsworth

First Name: Patti

Title: Assistant Commissioner, Chief of LTSS

Agency: Bureau of TennCare

Address: 310 Great Circle Road

Address 2:

City: Nashville

State: **Tennessee**

Zip: 37243

Phone: (615) 507-6468 **Ext:** ☐ **TTY**

Fax: (615) 741-1092

E-mail: Patti.Killingsworth@tn.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Doutre

First Name: Laura

Title: Assistant Commissioner of Policy and Innovation

Agency: Department of Intellectual and Developmental Disabilities

Address: 15th Floor, Andrew Jackson Building

Address 2: 500 Deaderick Street

City: Nashville

State: **Tennessee**

Zip: 37243

Phone: (615) 532-5450 **Ext:** ☐ **TTY**

Fax: (615) 532-9940

E-mail: laura.doutre@tn.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Patti Killingsworth

State Medicaid Director or Designee

Submission Date: Mar 12, 2015

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Killingsworth

First Name: Patti

Title: Assistant Commissioner, Chief of Long-Term Services and Supports

Agency: Bureau of TennCare

Address: 310 Great Circle Road

Address 2:

City: Nashville

State: **Tennessee**

Zip: 37243

Phone: (615) 507-6468 **Ext:** ☐ **TTY**

Fax: (615) 741-1092

E-mail: patti.killingsworth@tn.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- [ ] **Replacing an approved waiver with this waiver.**
- [ ] **Combining waivers.**
- [ ] **Splitting one waiver into two waivers.**
- [ ] **Eliminating a service.**
- [x] **Adding or decreasing an individual cost limit pertaining to eligibility.**
- [ ] **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- [ ] **Reducing the unduplicated count of participants (Factor C).**
- [ ] **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- [x] **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- [ ] **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Statewide Waiver Transition Plan for 2015 Waiver Renewal

Introduction:

Effective upon renewal of the Statewide waiver (CMS Control #0128), Tennessee will apply an individual cost neutrality cap to program participants based on the average annualized cost of services in a private ICF/IID. In order to minimize the potential for disruption in services for Statewide waiver participants, prior to implementation of the individual cost neutrality cap, individuals identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide waiver will be transitioned into the state's Arlington (to be renamed upon renewal the Comprehensive Aggregate Capped or CAC) waiver (CMS Control #0357), which will continue to operate with an aggregate cap. Individuals transitioning into the CAC waiver to ensure continuity of services and individuals remaining enrolled in the Statewide waiver who will be subject to the individual cost neutrality cap will receive a notice 30 days in advance of the effective date of the respective changes.

Notice to Individuals:

All individuals enrolled in the current Statewide waiver will receive one of two notices from the State Medicaid Agency:

1. Individuals identified by the State for transition into the CAC waiver will receive a 30-day advance notice of their enrollment change from the Statewide waiver to the CAC waiver. The notice explains:
• An individual cost neutrality cap is being applied to individuals enrolled in the Statewide waiver.
• They will be transitioned to the CAC waiver to ensure continuity of waiver services.
• The kinds of services available in the CAC waiver are the same kinds of services they receive now.
• Their services will not change because they are moving to the new CAC waiver.
• Individuals can keep using the same waiver providers, including the same ISC (Independent Support Coordinator).

2. Individuals who will remain enrolled in the Statewide waiver and be subject to the new individual cost neutrality cap will receive a 30-day advance notice that an individual cost neutrality cap will be applied to their waiver services. The notice explains:
• The Statewide waiver has been renewed so that the people receiving services can continue to receive them.
• There will be an individual cost cap on the total cost of waiver services that each person enrolled in the Statewide waiver can receive each year.
• The amount of the cost cap is the average cost of services in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
• If an individual's needs change, their ISC will help them look at other ways to meet their needs.

Pursuant to 42 CFR 431.220(b), these notices do not advise enrollees of the right to request a fair hearing, since, upon approval of the Statewide waiver, the individual cost neutrality cap will be applied to all waiver participants and is being

implemented in a way that will result in no reductions in services (i.e., no adverse action) for program participants. This includes individuals transitioning from the Statewide waiver to the CAC waiver who are being transitioned in order to avoid reductions in services that would otherwise result from being subject to the new cost cap.

Continuity of Services/Care:

Individuals transitioning from the Statewide waiver to the CAC waiver will not experience a reduction in services or have new limits applied to services they are receiving as a result of the transition.

• All services that are available in the Statewide waiver are also available in the CAC waiver.
• Service definitions in both the Statewide and the CAC waivers are the same.
• Benefit limits that are applied in the Statewide and the CAC waivers are the same.

Transition Timeline:

• Notification of approved waiver received from CMS - TBD
• TennCare IT systems generate notices to individuals (notices have been drafted and IT changes have been developed and tested; notice generation process will commence upon receipt of waiver approval).
• Each current Statewide waiver enrollee will receive a-30 day advance notice (as described above) before the applicable change is effective.
• Enrollees transitioning to the CAC waiver will be transitioned upon expiration of the 30-day advance notice period.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Tennessee Home and Community Based Services Settings Rule
Transition Plan

Tennessee's State Medicaid Agency (SMA), the Bureau of TennCare (TennCare) submits this proposed Transition Plan in accordance with requirements set forth in the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) Settings Rule released on January 16, 2014.

In preparation for development of the state's proposed Transition Plan, TennCare completed certain activities believed to be pertinent to the development of the Transition Plan. Those activities are detailed below. Detailed Provider Self-Assessment and Individual Experience tools and the Assessment Worksheet, including instructions with timelines, will be submitted separately to the CMS regional project officer.

Section 1: Transition Plan Development and Public Input Activities (Forms of Public Notice)

1) Provider information meetings
a) Invitations were posted on the TennCare website and distributed through provider and advocacy organizations, the Department of Intellectual and Developmental Disabilities (DIDD) and contracted Managed Care Organizations (MCOs). They will be submitted separately to the CMS regional project officer.

b) Seven separate meetings were held across the state between July 8-24, 2014.
c) 628 attendees in total
d) Power point presentation was posted on the TennCare website on July 25, 2014 and submitted separately to the CMS regional project officer.

2) Consumer and family information materials and meetings
a) Consumer/family friendly materials were developed with input from provider and advocacy organizations.
b) Materials were posted on the TennCare website and distributed through provider and advocacy organizations, DIDD and MCOs.
c) TennCare hosted 2 open forum conference calls to educate consumers and families on the HCBS Settings Rule and the importance of their public input.
i. There were a total of 251 distinct phone numbers that accessed the calls, but since there were several participants who were gathered in groups, the actual number of participants is unknown, but greater than the number represented by distinct phone numbers.
ii. HCBS providers participated in these calls as well as consumers and families.
d) Some providers held family meetings as well.
e) Copies of these materials were submitted separately to the CMS regional project officer.

3) State posting of draft transition plan and assessment tools for public comment
a) All Transition Plan and Assessment Tool documents were posted at: http://tn.gov/tenncare/long_hcbstransition.shtml. Individuals could provide comments online through the website, via the US postal service, or by emailing program staff directly.
b) The comment period extended from July 25, 2014 – September 19, 2014 as an interactive, working time between the state, providers, advocates, consumers and families. TennCare updated documents based on comments received and reposted the documents to the TennCare website as updated drafts.
i. The Transition Plan was revised based on:
1. Public comments received regarding timelines and assessment activities; and
2. Feedback received from CMS, including removal of Person-Centered Planning (PCP) components.
3. The proposed Transition Plan was revised and reposted on September 18, 2014.
c) Documents were finalized (with any additional comments received), posted and entered into CMS web portal with waiver submission October 1, 2014.
d) Cover letter, assessment tools and assessment tools instructions were submitted separately to the CMS regional project officer.
e) The final version of the Transition Plan submitted to CMS was posted on the TennCare website.

Section 2: Transition Plan Components

Part A: SMA Self-Assessment and Remediation
1) SMA self-assessment process: Ongoing – February 28, 2015
a. The state has initiated ongoing internal strategy meetings to prepare for and begin assessing all rules, regulations, policies, protocols, practices and contracts.
b. The state will develop and implement strategies for consumer and family, provider, advocate, and other stakeholder input into the self-assessment of state standards, requirements and practices.
c. Components of the SMA Self-Assessment shall include, at a minimum, the following:
i. HCBS definitions and provider qualifications: Proposed changes to waiver definitions are included in waiver renewal applications and amendments. Any subsequent changes identified will be submitted as waiver amendments.
ii. State law: The SMA will work in collaboration with DIDD as it relates to Title 33. Statutory revisions (including authority to revise licensure and other rules, as applicable) will be submitted during the upcoming legislative session. Tennessee's legislative session is January – April/May each year. State regulations: Rules requiring modification may include those that are under the authority of another state department. In addition to promulgating revised regulations under its own purview, as determined to be appropriate, the SMA will provide appropriate education and explanation to other state departments regarding need for any rule revisions, which the SMA will formally request in writing, in order to allow the state to come into compliance as applicable. Proposed legislation in the upcoming session will provide statutory obligation and authority to make such rule revisions.
iii. Policies, protocols, and practices (including Quality Management practices)
iv. Training requirements
v. Contracts, rate methodology, and billing practices: This will include contracts/Interagency Agreements the SMA currently holds with DIDD and the MCOs.
vi. Information Systems
vii. Specific timelines and milestones for achieving compliance with the new federal rules will be established as

needed changes are identified, and included in an amendment to the State Transition Plan.

Part B. Contracted Entity Self-Assessment and Remediation
2) Contracted entity self-assessment process: October 1, 2014 – March 31, 2015

a. The DIDD and MCOs will be required to review all policies, procedures and practices (including Quality Management practices), training requirements, contracts, billing practices, person-centered planning requirements and documentation, and information systems to determine their compliance with the HCBS Settings Rule. Each entity will be required to submit its assessment along with evidence of compliance to the SMA. Each entity will also be required to identify any modifications needed to achieve compliance with the HCBS Settings Rule. The SMA will review each entity's self-assessment and evidence of compliance to ensure that all aspects of the system are congruent with CMS expectations and will allow the State to operate HCBS programs in a manner which comports with the HCBS Settings Rule. The SMA will request any additional information needed to assess compliance. Any changes needed to achieve compliance will be incorporated in an amendment to the State Transition Plan, including specific timeframes and milestones.

b. All revisions to policies, procedures, training requirements, etc. needed to achieve compliance with the new Rule will be submitted to the SMA for review and approval, and implementation will be tracked by the State in accordance with approved timeframes.

c. Upon approval, final versions will be completed and distributed to providers.

d. Provider education/training will be conducted as appropriate. All education and training materials will be led by or reviewed and approved by the SMA.

e. Specific to DIDD, in instances where a change in rule or policy requires a public comment period, time lines will be adjusted accordingly to accommodate time needed to process and respond to public input and incorporate such comments into document revisions.

Part C. Provider Self-Assessment and Remediation
3) Provider self-assessment process: October 15, 2014 – March 31, 2015

a. The State will conduct statewide provider education and training sessions on how to complete the Provider Self-Assessment Tool. These training sessions will be conducted between October 15, 2014 – November 15, 2014.

b. Providers will receive the applicable Provider Self-Assessment Tool with the Assessment Tool instructions and time lines. At a minimum, all HCBS residential, employment and day program, and PA providers will be required to complete a self-assessment.

c. Providers will be required to include persons served, family members/representatives, advocates, and other stakeholders in their assessment process.

d. Providers will be required to include in their self-assessment a description of their self-assessment process, including participation of the aforementioned persons.

e. Providers will submit their respective Self-Assessment along with specific evidence of compliance for further review by the SMA or its designee (DIDD or MCOs). Additional evidence may be requested or further reviews conducted as needed to further assess and validate compliance with these rules.

f. Providers who self-report or are assessed to be non-compliant with the HCBS Settings Rule will be required to submit a Provider Transition Plan identifying the area(s) of non-compliance and describing their proposed plan for coming into compliance along with associated time lines. Information regarding Provider Transition Plans and specific timelines for achieving compliance will be incorporated in an amendment to the State Transition Plan.

g. All completed and validated Provider Transition Plans will be reviewed and approved by the DIDD or MCO as applicable, and implementation will be monitored based on approved timeframes, with oversight by the SMA.

h. Providers needing assistance to achieve compliance may request such assistance from the entity with whom they are contracted (DIDD or MCO), another (compliant) provider of the same service type, and/or consumers and family members or advocates.

i. Providers assessed to be unwilling or unable to come into compliance, will be required to cooperate with transition assistance to ensure all individuals served are transitioned to an appropriate provider type, maintaining continuity of services.

i. The SMA, in conjunction with DIDD or the MCOs, as applicable, will oversee all necessary transition processes:

1. A minimum of 30 days notice will be given to all persons needing to transition between providers. More notice may be granted in instances when residential services are being secured.

2. A description of the process and choice of appropriate providers will be included with each notice. The person's ISC, case manager or care coordinator, as appropriate, will conduct a face to face visit as soon as possible to discuss the transition process and ensure they understand any applicable due process rights.

Part D. Individual Experience Assessment
4) Individual Experience Assessment process: November 1, 2014 – October 31, 2015

a. Each individual's ISC, case manager or care coordinator, as applicable, will assist the individual and his/her family member/representative, as appropriate, in completing an initial Individual Experience Assessment. Service provider staff may

participate as requested by the individual and his/her family member/representative.

b. Such assessments will be conducted, beginning November 1, 2014 during the individual's annual person-centered plan review, or sooner if an amendment or plan review is conducted prior to the annual review.

c. This initial assessment period will be ongoing for one year to allow each ISC, case manager and care coordinator the opportunity to conduct the Individual Experience Assessment while completing a scheduled annual review or needed amendment.

d. For provider owned/controlled settings, any proposed modification of requirements set forth in the HCBS Settings Rule for the individual shall be reviewed to confirm that:

i. There is a specific individualized assessed need for such modifications;

ii. Prior interventions and supports including less intrusive methods have been tried and demonstrated to be unsuccessful;

iii. The proposed modification is appropriate based on the specific need identified; and

iv. The proposed modification, including interventions and support will not cause harm to the individual.

e. Each of the above items (i.-iv.) shall be documented in the person-centered plan, along with:

i. The method of collecting data on an ongoing basis to measure the effectiveness of the modification; and

ii. A specific time limit for periodic review of the data and the effectiveness of the modification to ensure it continues to be appropriate.

f. The individual shall provide informed consent of the proposed modification.

g. If a modification to the HCBS Settings Rule is determined to be inappropriate based on the person's individualized needs (and in accordance with the requirements above), the area identified as non-compliant will trigger a new assessment of the provider, as applicable, and a Transition Plan developed by the provider to address any issues of non-compliance will be submitted to the contracting entity for review, approval and monitoring of implementation.

Part E. Achieving Initial Compliance

No later than December 31, 2015, upon review and validation of State, contracted entity, and provider self-assessments, the State will submit an amendment to the State Transition Plan with specific remediation activities and milestones for achieving compliance with the HCBS Settings Rule.

In addition, no later than December 31, 2015, the State will submit an amendment to this waiver that will include the fully developed State Transition Plan, with timelines and milestones for achieving compliance with the HCBS settings requirements in the final rule.

For providers needing assistance to come into compliance the state proposes to implement the following strategies, January 1, 2015 – December 31, 2016:

• Facilitate focus groups of non-compliant and compliant providers who can talk through provider specific issues and problem-solve how to achieve compliance together. Participation will be voluntary and can include consumers and family members who may aid in the problem solving process.

• Provide one-on-one technical assistance (TA) (TA will be provided upon request by the DIDD, MCO and or SMA as appropriate)

Part F. Assuring Ongoing Compliance

Once overall compliance is achieved, strategies to ensure ongoing compliance will include:

• Incorporating the Individual Experience Assessment (as described above) into all initial and annual person-centered plan reviews

• Quality assurance methodologies will incorporate monitoring performance measures that ensure compliance with HCBS Settings and PCP Rules

• Annual consumer/family satisfaction surveys

• The State will also explore the use of Core Indicators data and national accreditation standards to support its ongoing compliance monitoring efforts.

Transition Plan Public Comments

The State received 35 online comments, 21 comments via mail, and 4 comments via email, totaling 60 written public comments. (These were written comments from 60 submitting entities; most entities submitted multiple comments/recommendations.) These included three letters from advocacy groups: one from The Arc Tennessee; another from the Tennessee Parent Coalition encompassing parents of individuals with I/DD across the state, including Nashville, Memphis, and Chattanooga; and the third from the TennesseeWorks Partnership Team and Employers and Providers Workgroup. The vast majority of comments received were from family members, conservators, or representatives of individuals with disabilities served in the state's HCBS programs.

Of the 60 written comments received, 5 were not applicable to the Transition Plan or Assessment documents, and 21 were specific to concerns about the potential elimination of facility based day services under the new HCBS setting regulation. Comments were also received during face-to-face meetings with various provider groups and during statewide informational calls targeted to individuals with I/DD and their family members or conservators. A summary of the comments pertaining directly to the Proposed Transition Plan and changes to the Transition Plan based on those comments is below.

Summary of Comments on Transition Plan and Changes Made

In order to help organize comments for incorporation into the Transition Plan, the State asked entities submitting comments to answer certain questions regarding the Transition Plan. Entities were also encouraged to submit any other comments or recommendations beyond the scope of these questions.

1. Are the suggested timelines appropriate?

• Almost all of the commenters focused on the timeline set forth in the regulation for achieving compliance with the HCBS Setting Rule, rather than the specific timelines proposed in Tennessee's Transition Plan. The majority of these commenters stated that they believe the full 5 years will be necessary for transition and 3 years at minimum. (The State has not yet established a deadline for achieving full compliance, and recognizes that any proposed date is subject to CMS approval. This date will be determined based on state, contracted entity, and provider self-assessments, as well as action steps and timelines for achieving compliance, but will occur no later than March 17, 2019.)

Concerns were expressed, however, with the proposed timeframes for completing provider self-assessments and contracted entity self-assessments. Based on these comments, the State modified the Transition Plan to extend the timelines for submission of these self-assessments, incorporating a training period for providers on the new tool, as further described below. These changes in the Transition Plan are addressed in Part B, 2 and Part C, 3 with the extension of Contracted Entity Self-Assessment and Provider Self-Assessment activities, respectively, from December 31, 2014 to March 31, 2015.

2. The best methodology/process for completing the assessments?

• The majority of commenters declined to make specific recommendations regarding the process.

• Several commenters recommended training for providers on the self-assessment process prior to its implementation. (This comment was addressed in Part C, 3) with the addition of "a. The State will conduct statewide provider education and training sessions on how to complete the Provider Self-Assessment Tool. These training sessions will be conducted between October 15, 2014 – November 15, 2014.")

• Several commenters also affirmed the importance of self-advocate and family involvement in all aspects of the assessment process, and recommended that the Transition Plan reflect ways to ensure that their perspective would be included in the assessment of compliance with the new rule. (This comment resulted in a change in Part C, 3, c. Providers will be required to include persons served, family members/representatives, advocates, and other stakeholders in their assessment process.)

• Some commenters expressed concern regarding individuals who may be required to transition to new providers should their current providers not come into compliance with the new rule. (This comment resulted in the addition of a new i. under Part C, 3 ,i., reflecting the oversight of the SMA, in conjunction with DIDD or the MCO, as applicable, in all necessary transition processes.)

3. Strategies for initial achievement of compliance and assurance of ongoing compliance?

The majority of commenters responded that they need more guidance from CMS, particularly on non-residential services. Providers and families expressed significant concern regarding the potential impact of the new rule on facility-based day services, and whether such services will continue to be permitted under HCBS programs. (TennCare received verbal guidance from CMS on non-residential service compliance which will be addressed in provider training, and is proceeding accordingly. The State will incorporate into its Transition Plan assessment and compliance processes any additional written guidance that may be issued by CMS, as it becomes available.)

Many commenters expressed satisfaction with the current services provided in Tennessee, affirming their belief that programs are person-centered and operating in compliance with the new rule, and are concerned that changes related to the rule will disrupt services for members—in particular, facility-based day services.

• There were recommendations that the State also consider other ways of measuring ongoing compliance in addition to the individual experience assessments. (This resulted in the addition of a 4th bullet under Part F, exploring the use of Core Indicators data and national accreditation to support ongoing compliance monitoring efforts.)

4. OTHER comments

• The overwhelming majority of commenters again expressed concern about the effect the HCBS Setting Rule will have on facility-based day services. Most of these commenters are concerned that Tennessee will do away with facility-based day programs in part or altogether, and strongly oppose such changes. (This comment did not impact changes necessary to the Proposed Transition Plan; verbal guidance received from CMS will be addressed in provider training and ongoing communication with stakeholder groups.)

• Other comments requested changes in certain language, e.g., not using "plan of care."
("Plan of care" has been changed to "person-centered plan" throughout the Transition Plan

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
Department of Intellectual and Developmental Disabilities (DIDD)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The

interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The Statewide Waiver is operated by the Department of Intellectual and Developmental Disabilities (DIDD) through an interagency agreement with the Bureau 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 Bureau of TennCare is the state's medical assistance unit and is located within the Department of Finance and Administration’s Division of Health Care Finance and Administration. The TennCare Director, who serves as a Deputy to the Commissioner of the Department of Finance and Administration and head of the Division of Health Care 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 approval of 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. Responsibility is delegated to DIDD and monitored by TennCare for waiver enrollment, 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 functions 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 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 communications to providers and persons supported.

In addition to ongoing informal communication processes, monthly meetings between TennCare and DIDD ensure adequate TennCare oversight. Monthly meetings include:

• The Interagency Executive and Senior Leadership Meeting: Executive and Senior leadership of TennCare and DIDD meet on at least a monthly basis to discuss issues pertaining to operation and oversight of this (and other) HCBS waiver program(s) for individuals with intellectual disabilities.

• 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 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 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 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. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative

functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** 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:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** 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
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

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.3. Number and percentage of individual findings regarding provider (including staff) qualifications that were appropriately and timely remediated by DIDD. [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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Quality Management Reports, DIDD Discovery and Individual Remediation Data Files

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**	☐ **Weekly**	☑ **100% Review**

Agency		
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
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.

Data Source (Select one):

Other
If 'Other' is selected, specify:
TennCare Policy Review Log; DIDD Quality Managment Report; DIDD Discovery and Individual Remediation Data Files

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.7. Number and percentage of substantiated cases of abuse, neglect and exploitation that were appropriately and timely remediated by DIDD. [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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Quality Management Report; DIDD Discovery and Individual Remediation Data Files

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.4. # and % of individual findings regarding Individual Support Plans that were appropriately and timely remediated by DIDD.[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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Quality Management Reports; DIDD Discovery and Individual Remediation Data Files

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.2. Number and percentage of individual findings regarding level of care reevaluation that were appropriately and timely remediated by DIDD. [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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Quality Management Report; DIDD Discovery and Individual Remediation Data Files

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.8. Number and percentage of inappropriate provider claims identified via post-payment review processes that were appropriately and timely remediated by DIDD. [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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Quality Management Reports; DIDD Discovery and Individual Remediation Data Files

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
TennCare Utilization Review Findings

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
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. [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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Quality Management Reports; DIDD Discovery and Individual Remediation Data Files

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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.

b. 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 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 subassurance 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 subassurance.

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. TennCare will hold DIDD accountable for timely remediation of all individual issues identified. TennCare routinely monitors DIDD monthly remediation reports to determine if acceptable remedial activities have been completed. DIDD 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 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.

Individual Remediation Data Aggregation: DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible DIDD staff and back-up staff are identified for each task. Designated DIDD Central Office staff compile the data collected and entered by regional and central office staff into DIDD databases to create data files that are posted for TennCare analysis and aggregation. In addition, DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	0	5	☐
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

a. Meet TennCare ICF/IID level of care criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PreAdmission Evaluation approved by TennCare;

b. Have been assessed and found to:

i. Have an intellectual disability manifested before eighteen (18) years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); or,

ii. Have a developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in an intellectual disability and be a child five (5) years of age or younger.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

It is often difficult to diagnose children under the age of 5 as having an intellectual disability as defined in Tennessee Code Annotated, Title 33-1-101.

Children who enter the waiver between the ages of 0-5 with a diagnosis of developmental disability, are evaluated before age 6 to determine if they have a condition of mental retardation as defined in Tennessee Code Annotated, Title 33-1-101. Upon attaining age six (6) years, if a child in the Statewide waiver is found to no longer meet level of care, the Medicaid agency will ensure the continuation of EPSDT services for children who remain Medicaid eligible, and for both Medicaid-eligible and non-Medicaid-eligible children, help identify, through other community resources, other types of assistance that can help address the child and family's ongoing support needs.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- ○ **A level higher than 100% of the institutional average.**

  Specify the percentage:

- ○ **Other**

  Specify:

- ◉ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Prior to enrollment into the Statewide Waiver Program, an individualized assessment of need is conducted by DIDD intake staff. The purpose of this assessment is to identify the services/supports needed by the applicant and to determine whether the applicant's needs can be safely met within the array of benefits available if enrolled in the waiver in a manner that assures the individual's health and welfare.

An initial plan of care must be submitted with the level of care application to TennCare for review. TennCare nurses review the initial plan of care along with the level of care application to further confirm that the services/supports are appropriate based on the level of care assessment, and can be provided within the institutional cost limit established for the waiver (i.e., the annualized average per diem cost of services in a private ICF/IID).

If a person is denied admission to the Statewide waiver because TennCare or DIDD has determined, based on an individualized assessment, that the applicant's needs cannot be safely met in a manner that assures his health and welfare, and he is not willing or qualified to enroll in a different waiver where his needs could be safely met, notice of enrollment denial, including the right to fair hearing, would be issued. The applicant would have 30 days to request a fair hearing from TennCare. Fair hearings regarding denial of enrollment into an HCBS waiver are conducted in accordance with the Uniform Administrative Procedures Act.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☑ **Other safeguard(s)**

Specify:

Should a change in the participant's condition or circumstances post-entrance to the waiver require the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, TennCare and DIDD will first work with the Independent Support Coordinator and with the participant's MCO to determine whether additional services and supports needs can be met through covered or cost-effective alternative services available through the managed care program, allowing the person to continue participation in the waiver program. If, following such coordination efforts, it is determined that the participant's health and welfare cannot be assured in the waiver, TennCare and DIDD will work with the individual to facilitate transition to another more appropriate LTSS program or service. Upon its approval and implementation, this will include the new Managed Long Term Services and Supports Program, Employment and Community First CHOICES. Notice of disenrollment, including the right to fair hearing, would be issued. The applicant would have 30 days to request a fair hearing from TennCare. Fair hearings regarding disenrollment from an HCBS waiver are conducted in accordance with the Uniform Administrative Procedures Act.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5072
Year 2	5072
Year 3	5072
Year 4	5072
Year 5	5072

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry to the Statewide Waiver is available only to Tennessee residents in the target populations who:
1. Meet Medicaid financial eligibility criteria in one of the specified eligibility groups;
2. Need the level of care provided in an Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) as evidenced by TennCare approval of a Pre-Admission Evaluation (PAE);
3. Meet all applicable requirements set forth in TennCare Rule Chapter 1200-13-1-.25, including a determination by DIDD that the individual's medical, behavioral and specialized services and support needs can be safely met through

the Waiver, based on a pre-enrollment assessment, and a place of residence with an environment that is adequate to reasonably ensure the person's health, safety and welfare.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**
2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]
- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the State plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
  - ○ **Other standard included under the State Plan**

    Specify:

- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**

  Specify:

- ● **Other**

  Specify:

  200% of the SSI Federal Benefit Rate (FBR)

ii. Allowance for the spouse only (*select one*):

- ● **Not Applicable**
- ○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

  Specify:

Specify the amount of the allowance (*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

Specify:

- **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The State does not establish reasonable limits.**
- ◉ **The State establishes the following reasonable limits**

Specify:

Deductions for any other medical services recognized under State law but not covered by Medicaid will be provided per contract of the providers usual and customary charges, billed charges, or 80% of the Medicare fee schedule. Deductions will be allowed only for services that are determined by the state to be medically necessary for the particular individual on whose behalf the services are being requested.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage: [ ]
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

Specify formula:

- (●) **Other**

Specify:

200% of the SSI-FBR

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- (●) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

◉ **Other**
Specify:

1. The Bureau of TennCare, the State's Medical Assistance Unit, which is within the Department of Finance and Administration, is responsible for performing the initial level of care evaluations (PAEs).

2. The Department of Intellectual and Developmental Disabilities (DIDD) is responsible for the annual level of care reevaluation.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Physician (M.D. or D.O.) or Registered Nurse, licensed in the State of Tennessee

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Initial Level of Care Criteria: The State's level of care criteria for the Home and Community-Based Services Waiver for Persons with Mental Retardation specify that the applicant must meet ICF/IID level of care criteria, as verified by approval of the PreAdmission Evaluation (PAE) for ICF/IID Care (the State's level of care assessment tool). Those criteria are as follows:
1. Have a diagnosis of intellectual disability manifested before eighteen (18) years of age; and
2. Require a program of specialized services for intellectual disability or related conditions provided under the supervision of a qualified intellectual disability professional (QIDP); and
3. Have a significant deficit or impairment in adaptive functioning in one of the following areas: communication, comprehension, behavior, or activities of daily living (e.g., toileting, bathing, eating, dressing/grooming, transfer, mobility).
Level of Care Criteria for Reevaluation: There are four level of care requirements that must be met for continued enrollment in the waiver during the reevaluation process. The person supported must:
1. Need the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/IID.
2. Require services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability.
3. Have a significant deficit in impairment in adaptive functioning involving communication, comprehension, behavior, or activities of daily living (i.e., toileting, bathing, eating, dressing/grooming, transfer, or mobility); and
4. Require a program of specialized supports and services provided under supervision of a Qualified Intellectual Disability Professional (QIDP).

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the

evaluation process, describe the differences:

The initial evaluation requires a Pre-Admission Evaluation (PAE) to be completed.

Applicants are screened by the Department of Intellectual and Developmental Disabilities (DIDD) to determine that they have a diagnosis of an intellectual disability prior to age 18. When an applicant is determined to be likely to require the level of care provided by an ICF/IID, DIDD informs the individual or the individual's representative of any feasible alternatives under the waiver program and offers the choice of either institutional or waiver services.

DIDD conducts a pre-enrollment assessment. DIDD submits the Pre-Admission Evaluation (PAE) for ICF/IID Care to the Bureau of TennCare, the state Medicaid agency. The Bureau of TennCare determines whether the person meets the ICF/IID level of care.

DIDD is responsible for completing annual reevaluations. A physician, a registered nurse, or a Qualified Intellectual Disabilities Professional must attest that the participant meets the four requirements for reevaluation described in (d.) above.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**
  Specify the qualifications:

  Qualifications of professionals who conduct annual reevaluations are:

  - Physician, either a D.O. or M.D.;

  - Registered Nurse licensed in the State of Tennessee; or

  - Qualified Intellectual Disabilities Professional (QIDP), as defined in 42 CFR 483.430(a)

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Each DIDD regional office tracks and monitors annual level of care reevaluations due dates through the DIDD Client Information Tracking System on a monthly basis to ensure timely receipt.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Initial Level of Care Evaluations: Initial Level of Care evaluation determinations are made by the Bureau of TennCare which maintains all applicable written and electronic documentation for a minimum of 3 years.

Annual Level of Care Reevaluations: Annual Level of Care Reevaluations are conducted by DIDD, which maintains all applicable written and electronic documentation for a minimum of 3 years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.2. Number and percentage of new waiver participants for whom level of care eligibility was approved prior to enrollment in the waiver. Percentage = number of newly enrolled waiver participants for whom level of care eligibility was approved prior to enrollment in the waiver / total number of newly enrolled waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TennCare MMIS Report for Edit 2008: "No PAE on File."

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.1. Number and percentage of initial level of care determinations made by a qualified evaluator (i.e. Registered Nurse). Percentage = number of LOC determinations made by a qualified evaluator / total number of LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TennCare PAE Excel Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.c.7. Number and percentage of ICF/IID level of care eligibility determinations made within 8 working days of receipt of application. Percentage = Number of determinations made within 8 days/ total number of applications received.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
TennCare PAE Tracking Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.c.3. Number and percentage of initial LOC determinations made for which LOC criteria were accurately and appropriately applied. Percentage = number of initial LOC determinations made for which LOC criteria were accurately and appropriately applied/ total number of initial LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TennCare Sample Peer Reveiws

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		+/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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.
Note: performance measures a.i.b1 and a.i.c.6 were deleted per the CMS Modifications to Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, which deleted the related subassurance requiring that "The levels of care of enrolled participants (persons supported) are reevaluated at least annually or as specified in the approved waiver".

Performance Measures a.i.c.3: TennCare will select a monthly sample of PAEs reviewed for ICF/IID level of care during the previous month. For each PAE in the sample, a PAE Nurse who was not involved in the original review will be assigned to conduct a “follow-behind” review to ensure ICF/IID level of care criteria were appropriately utilized in approving or denying the PAE.

b. 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.: Actual enrollment into the Statewide Waiver is managed by TennCare once all necessary requirements have been met. This includes the loading of an approved PAE (i.e., level of care) eligibility segment into the MMIS. Thus, enrollment is not permitted without a level of care determination. Further, the TennCare MMIS Edit 2008 does not allow payment for waiver services until an approved PAE is entered into the MMIS. Edit reports generated from the MMIS will be utilized for TennCare staff to identify instances where claims for waiver services were denied due to the absence of a PAE eligibility segment. When such instances are discovered, TennCare staff will investigate whether the unit neglected to enter the PAE information into the system or whether a claim was submitted when there was no current approved PAE on file. If TennCare staff failed to enter the PAE information in the system, the error will be corrected upon discovery and staff who made the error will be counseled as appropriate. If a claim was submitted before a PAE was approved or submitted or for an expired PAE, DIDD will be notified via the Remittance Advice Report. DIDD will be required to submit a PAE, update an expired PAE, or await approval of a pending PAE, as applicable Any payment will be contingent upon the effective date of level of care eligibility and enrollment into the waiver. Services provided prior to a person's level of care eligibility and enrollment into the waiver will not be reimbursed. TennCare's goal for resolution of claims denials related to "no PAE on file" is 30 calendar days.
Performance Measure a.i.c.1.: Only registered nurses employed and trained by TennCare to review PAEs may render a level of care decision. Only those PAEs approved by TennCare review nurses are entered into the MMIS to allow payment of claims. Upon discovery that an unqualified individual approved or denied a PAE, TennCare will assign a qualified TennCare PAE nurse to complete a re-review of the application within 8 business days. The corrected PAE with the signature of the qualified TennCare PAE nurse who approved the PAE upon re-review will be forwarded to the applicant and appropriate Case Manager within 3 business days of the re-review decision being made, with a cover letter explaining that the previous PAE is invalid and that the new PAE, signed by a qualified TennCare PAE reviewer, should be used to demonstrate medical eligibility for services. TennCare will then apply an end-date to the MMIS segment pertaining to the PAE approved in error, so that claims cannot be billed using that PAE. If an original PAE review results in approval by an unqualified reviewer, and such approval is determined to be in error upon re-review, TennCare will send a corrected denied PAE (including the signature of the qualified TennCare PAE reviewer) to the appropriate DIDD case manager and a notice of denial to the waiver participant (persons supported), copied to the appropriate Support Coordinator. Both will be issued within 3 business days of the new determination being made. The notice of denial will include a description of applicable appeal rights. A cover letter will be attached advising the applicant that a wrongful determination was made by an unqualified reviewer and that DIDD will be required to begin disenrollment procedures upon exhaustion of appeal rights. DIDD will complete and issue a waiver disenrollment notice (reviewed by TennCare prior to issuance) if no appeal is received within 30 calendar days of the waiver participant's receipt of the erroneous PAE approval notice. If an appeal is received within 30 calendar days of the waiver participant's receipt of the notice and a fair hearing is held, DIDD will issue notice of disenrollment upon receipt of a final order indicating that the applicant is ineligible for waiver services. In the event that the applicant is approved via the fair hearing, waiver funds will be used to pay for service claims. If the applicant is finally determined to be ineligible through appeal processes, the state will not claim FFP for reimbursement of services rendered prior to disenrollment. TennCare will track and report the number of PAEs re-reviewed due to prior disposition by an unqualified reviewer as well as approvals, denials, and appeals generated by re-reviews.
Performance Measures a.i.c.7: When TennCare review of the PAE process determines that ICF/IID PAEs were not completed within 8 business days of receipt, the PAE Unit Supervisor will verify that the PAE has been properly completed, determine why the PAE was not completed timely, and counsel staff and/or adjust operational procedures as necessary. Remediation is expected within a targeted time frame of 30 calendar days.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

FREEDOM OF CHOICE

1. When an individual is determined to qualify in the target group specified for the Statewide waiver, and to meet all other applicable requirements for enrollment into the Statewide waiver, including ICF/IID level of care, and the waiver capacity has not reached the specified cap of unduplicated participants for the calendar year, the individual or his or her legal representative will be:
a. informed of any feasible alternatives under the waiver; and
b. given the choice of either institutional or Home and Community-Based services.

PROCESS:
The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:

When an individual is determined to require the level of care provided by an ICF/IID, DIDD shall inform the individual or the individual's legal representative of any feasible alternatives available under the waiver program, including a description of the waiver services and names and addresses of available qualified providers, and shall offer the choice of either institutional or waiver services.

Notice to the individual shall contain a simple explanation of the waiver and waiver services; a statement that

participation in the Waiver is voluntary; and notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment. The Freedom of Choice form shall be explained and the signature of the person to receive waiver services or the legal representative will be obtained on the Freedom of Choice form, which will be completed prior to admission into the waiver program.

In addition to freedom of choice of institutional or HCBS alternatives, individuals electing to participate in the Statewide waiver shall be supported to exercise 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.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of freedom of choice documentation are maintained in the following location(s):
The Freedom of Choice documentation will be maintained by contracted Support Coordination Agencies.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
For Individuals with Limited English Proficiency (LEP)

The Bureau of TennCare, the Department of Human Services, and the Department of Intellectual and Developmental Disabilities (DIDD) provide a number of options to assist individuals with Limited English Proficiency (LEP) as they navigate the application process for TennCare eligibility.

The Bureau of TennCare provides eligibility applications and mails notices in English and Spanish. An insert in each TennCare mailing provides information in each of the following languages and a toll-free phone number that individuals may call for translation assistance: Arabic, Kurdish-Bandinani, Kurdish-Sorani, Bosnian, and Vietnamese. Translation services are provided by the TennCare Advocacy Program, a program of Health Assist Tennessee. In addition to translation services, the TennCare Advocacy Program also assists TennCare enrollees and applicants with TennCare questions or problems, and can direct enrollees and applicants to other local community resources for translation and other assistance. DIDD also provides translation services as needed.

All notices contain the numbers of the TennCare Solutions Unit, the TennCare Advocacy Program and a TTY/TDD line.

The Bureau of TennCare provides a list of accommodations that are made available to the TennCare population. These accommodations include:

• Accepting online applications;
• Accepting applications submitted through the U.S. Mail;
• Allowing the applicant to designate a third party to represent him/her during the eligibility process;
• Conducting any interview or discussion that might be needed to gather additional information over the phone or outside of normal working hours;
• When needed because of the applicant’s disability, providing in-home assistance in completing the application process.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service	
Statutory Service	Residential Habilitation	
Statutory Service	Respite	
Statutory Service	Support Coordination	
Extended State Plan Service	Nursing Services	
Extended State Plan Service	Nutrition Services	
Extended State Plan Service	Occupational Therapy	
Extended State Plan Service	Physical Therapy	
Extended State Plan Service	Specialized Medical Equipment and Supplies and Assistive Technology	
Extended State Plan Service	Speech, Language, and Hearing Services	
Other Service	Adult Dental Services	
Other Service	Behavior Services	
Other Service	Behavioral Respite Services	
Other Service	Employment and Day Services	
Other Service	Environmental Accessibility Modifications	
Other Service	Family Model Residential Support	
Other Service	Individual Transportation Services	
Other Service	Intensive Behavioral Residential Services	
Other Service	Medical Residential Services	
Other Service	Orientation and Mobility Services for Impaired Vision	
Other Service	Personal Assistance	
Other Service	Personal Emergency Response Systems	
Other Service	Semi Independent Living	
Other Service	Supported Living	
Other Service	Transitional Case Management	

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

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Residential Habilitation shall mean a type of residential service selected by the person supported, offering individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a community-based setting and which supports each resident's independence and full integration into the community, and ensures each resident's choice and rights. Residential Habilitation services shall be provided in a dwelling which may be rented, leased, or owned by the Residential Habilitation provider, and shall comport 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.
All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP 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. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation, household chores) essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Residential Habilitation may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Residential Habilitation provider shall oversee the person's health care needs.
The Residential Habilitation dwelling shall be licensed by the State of Tennessee.
A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.
Individuals receiving Residential Habilitation services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted pursuant to state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work. A person supported who is receiving Residential Habilitation shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Residential Habilitation provider).

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, and in accordance with TennCare protocol, transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such.

Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling. Reimbursement for Residential Habilitation shall not include payment for Residential Habilitation provided by the spouse of a person supported. The Residential Habilitation provider and provider

staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Residential Habilitation provided by such individuals. Reimbursement for Residential Habilitation shall not include payment made for services provided by an individual who has been appointed as the conservator of the person supported, unless so permitted in the Order for Conservatorship.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Residential Habilitation shall not be provided in a home where a person supported lives with family members unless such family members are also persons supported. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

Residential Habilitation may be provided out-of-state under the following circumstances:
a. Out-of-state services shall be limited to a maximum of 14 days per person supported per waiver program year (i.e. calendar year).
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Waiver Service Agency
Provider Qualifications

License *(specify):*
Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility.
Certificate *(specify):*

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

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
Service:
Respite
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- (●) **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):*
Respite shall mean services provided to a person supported when unpaid caregivers are absent or need relief from routine caregiving responsibilities. Respite may be provided in the person's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/IID, in a home operated by a licensed residential provider, in a licensed respite care facility, or in the home of an approved respite provider. The Respite provider may also accompany the person on short outings for exercise, recreation, shopping or other purposes while providing respite care.
Reimbursement for Respite shall not include payment for Respite provided by the spouse of a person supported or family member or relative (whether by birth or marriage) who resides with the person supported in the home. The Respite provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Respite provided by such individuals. Reimbursement for Respite shall not include payment for Respite provided by any individual who has been appointed as the conservator for the person supported unless so permitted in the Order for Conservatorship. Family members who provide Respite must meet the same standards as providers who are unrelated to the person supported, including implementing services as specified in the individual support plan (ISP).
When less than 8 hours of respite services is needed in a day, the unit of reimbursement shall be per 15 minutes. When 8 hours or more of respite services are needed in a day, the unit of reimbursement shall be per day.
Level 1 per day reimbursement shall be for persons requiring at least 8 hours, but less than 16 hours of respite services in a day. Level 2 per day reimbursement shall be for persons requiring at least 16 and up to 24 hours of respite services in a day, but no awake overnight direct support staff. Level 3 per day reimbursement shall be for persons requiring 24 hour respite services, including awake overnight direct support staff.
Respite shall be limited to a maximum of 30 days per person supported per waiver program year (i.e. calendar year).
Family members are required to implement services as specified in the ISP. Reimbursement to family members shall be limited to forty hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person’s Circle of Support shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.
Providers who receive the per diem reimbursement rate for Respite shall be responsible for the cost of any Day Services needed while the person is receiving Respite services.
Respite Services shall not be provided during the same time period that the person supported is receiving Personal Assistance Services, Day Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite shall be limited to a maximum of 30 days per person supported per calendar year.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Respite Care Facility
Agency	Waiver Service Agency
Individual	Approved Respite Provider
Agency	Medicaid-certified ICF/IID
Agency	Licensed Residential Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Licensed Respite Care Facility
Provider Qualifications

License *(specify):*
Licensed respite care facility - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility if an ICF/IID or as an Intellectual Disability/Developmental Disability Respite Care Services Facility if not an ICF/IID.
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities(DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Waiver Service Agency

Provider Qualifications

License *(specify):*

Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Approved Respite Provider
Provider Qualifications
License *(specify):*
Approved Respite Provider - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Respite Care Services Facility if serving more than one individual.
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Medicaid-certified ICF/IID

Provider Qualifications

License *(specify):*

Medicaid-certified ICF/IID - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Institutional Habilitation Facility.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Residential Provider

Provider Qualifications

License *(specify):*

Licensed Residential Provider - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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

Service:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Support Coordination shall mean the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities to develop personal relationships, participate in their community, increase control over their own lives, and develop the skills and abilities needed to achieve these goals, person supported as specified in person supported the individual's person-centered Individual Support Plan (ISP). 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, 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; identification of what is important to the individual, including preferences for the delivery of services and supports; actual development, ongoing evaluation, and updates to the ISP as needed or upon request of the individual; coordination with the individual's health care providers and MCO(s), as applicable, to 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; 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 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 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 or upon request of the individual.
Support Coordination contacts shall include at least one face-to-face contact with the person supported per calendar month. If the person supported receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the person supported in the place of residence of the person supported each quarter (i.e. once every 3 months). If a person supported will need more frequent contacts from the ISC on an ongoing basis, such frequency should be specified in the ISP and Support Coordination shall be provided in accordance with the person's needs as specified in the ISP.
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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	ISC Agency
Individual	Individual Support Coordinator

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:
Agency
Provider Type:
ISC Agency
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Support Coordinator must have:

1. A Bachelor's degree from an accredited college or university in a human services field; or

2. A Bachelor's degree from an accredited college or university in a non-related field and one year of relevant experience; or

3. Associate degree plus two (2) years of relevant experience; or

4. Four (4) years of relevant experience.

Relevant experience means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.

Support coordinators who do not have a Bachelor’s degree in a human services field must be supervised by someone who does meet that qualification.

Support Coordinators must successfully complete required pre-service training courses as well as periodic in-service training and any other any re-training required to maintain approval to be a Support Coordinator.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Individual

Provider Type:

Individual Support Coordinator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Support Coordinator must have:

1. A Bachelor's degree from an accredited college or university in a human services field; or

2. A Bachelor's degree from an accredited college or university in a non-related field and one year of relevant experience; or

3. Associate degree plus two (2) years of relevant experience; or

4. Four (4) years of relevant experience.

Relevant experience means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.

Support coordinators who do not have a Bachelor's degree in a human services field must be supervised by someone who does meet that qualification.

Support Coordinators must successfully complete required pre-service training courses as well as periodic in-service training and any other any re-training required to maintain approval to be a Support Coordinator.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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:

Extended State Plan Service

Service Title:

Nursing Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
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. 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 the skilled nursing tasks to be performed. Nursing Services shall be provided face to face with the person supported by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.
Nursing Services shall also include the provision of services to teach and train the person supported and their family or other paid or unpaid caregivers how to manage the treatment regimen, and the provision of evaluation and training, specific to an individual person supported, by a registered nurse, for purposes of delegation of non-complex health maintenance tasks to unlicensed direct support staff, as determined appropriate by the delegating nurse, and as permitted by State law and contingent upon the registered nurse's evaluation of each individual's condition and also upon the registered nurse's evaluation of the competency of each unlicensed direct support staff. Evaluation, teaching and training required for delegation is considered part of the established rate; it is not billed separately.

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 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.
A single nurse may provide services to more than one individual receiving services in the same setting, provided each person's needs can be safely and appropriately met. 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 for each person supported, as applicable. Only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported. Documentation of service delivery must be kept for each person supported and shall reflect the total number of shared units of service provided, and the specific nursing tasks performed for that individual. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.
Nursing Services shall consist of 2 categories of services and reimbursement:
a. RN services: RN services shall mean skilled nursing services, as specified above, which are provided 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. LPN services: LPN services shall mean skilled nursing services, as specified above, which are provided 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.
This service shall be provided in home and community settings, as specified in the ISP, excluding schools, inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). A person supported who is receiving Medical Residential Services shall not be eligible to receive Nursing Services.
Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently.

Nursing Services are not intended to replace either intermittent home health skilled nursing visits or private duty nursing services available through the Medicaid State Plan/TennCare program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Nursing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nursing Services shall be limited to a maximum of 48 units (12 hours) per day per waiver participant.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Agency	Home Care Organization
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing Services

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
Registered nurse - Must be licensed by the Department of Health (TDH Rule 1200-8-34); Must be licensed to practice in Tennessee (TDH Rules 1000-1 & 1000-2)
Certificate *(specify):*
N/A
Other Standard *(specify):*
An LPN must work under the supervision of a licensed RN.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing Services

Provider Category:

Agency

Provider Type:

Home Care Organization

Provider Qualifications

License *(specify):*

Home care organization - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed nurses are licensed to practice in the state of Tennessee (TDH Rules 1000-1 & 1000-2))

Certificate *(specify):*

N/A

Other Standard *(specify):*

An LPN must work under the supervision of a licensed RN.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing Services

Provider Category:

Agency

Provider Type:

Waiver Service Agency

Provider Qualifications

License *(specify):*

Waiver service agency - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed nurses are licensed to practice in the state of Tennessee (TDH 1370-1 Rules 1000-1 & 1000-2)

Certificate *(specify):*

N/A

Other Standard *(specify):*

An LPN must work under the supervision of a licensed RN.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:
Annually

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:
Extended State Plan Service

Service Title:
Nutrition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*
Nutrition Services shall mean assessment of nutritional needs, nutritional counseling, and education of the person supported and of caregivers responsible for food purchase, food preparation, or assisting the person supported to eat. Nutrition Services must be provided in accordance with therapeutic goals and objectives specified in an ISP

that is specific for the individual receiving services and developed by a dietitian or nutritionist. A dietitian or nutritionist who provides Nutrition Services must provide services within the scope of licensure and must be licensed as required by the State of Tennessee. Nutrition Services are intended to promote healthy eating practices and to enable the person supported and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.
Nutrition Services must be provided face to face with the person supported except for training caregivers responsible for food purchase or food preparation on the specific needs of the person supported, or assisting the person supported to eat and except for that portion of the assessment involving development of the ISP. To the greatest extent possible, it is expected that the person supported is engaged in these activities as learning opportunities.
Nutrition Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Speech, Language, and Hearing Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently.
The unit of reimbursement for a Nutrition Services assessment with plan development shall be per day. The unit of reimbursement for other Nutrition Services shall be per day.
Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one assessment visit per waiver participant (person supported) per waiver program year (calendar year). Nutrition Services other than the assessment (e.g., person supported-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one visit per day.
Nutrition Services (including Nutrition Services assessments and other non-assessment services) shall be limited to a maximum of six (6) visits per waiver participant (person supported) per waiver program year (calendar year), of which no more than one (1) visit per waiver program year (calendar year) may be an assessment. A Nutrition Services assessment cannot be billed on the same day with other Nutrition Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Nutrition Services unless provided by a licensed dietitian or nutritionist.
Nutrition Services are not intended to replace services available through the Medicaid State Plan/TennCare program.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nutrition Services shall be limited to a maximum of six (6) visits per waiver participant per waiver program year (i.e. calendar year), of which no more than one (1) visit per waiver program year (i.e. calendar year) may be a Nutrition Services assessment.

Nutrition Services other than the assessment (e.g., service recipient-specific training of caregivers; monitoring dietary compliance and food preparation) shall be further limited to a maximum of one visit per day.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Organization
Agency	Waiver Service Agency
Individual	Dietitian or Nutritionist
Agency	Department of Intellectual and Developmental Disabilities acting as an Organized Healthcare Delivery System

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nutrition Services

Provider Category:
Agency

Provider Type:
Home Care Organization

Provider Qualifications

License *(specify):*
Home care organization - Must be licensed as a home care organization in Tennessee (TDH Rule 1200-8-8-.01) and ensure that employed nutritionists are licensed to practice in the state of Tennessee (TDH Rule 0470-1)

Certificate *(specify):*
N/A

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD).

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nutrition Services

Provider Category:
Agency

Provider Type:
Waiver Service Agency
Provider Qualifications
License *(specify):*
Waiver service agency - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed nutritionists are licensed to practice in the state of Tennessee (TDH Rule 0470-1)
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nutrition Services

Provider Category:
Individual
Provider Type:
Dietitian or Nutritionist
Provider Qualifications
License *(specify):*
Dietitian or Nutritionist - Must have a valid license to practice in Tennessee (TDH Rule 0470-1).
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nutrition Services

Provider Category:

Agency

Provider Type:

Department of Intellectual and Developmental Disabilities acting as an Organized Healthcare Delivery System

Provider Qualifications

License *(specify):*

Waiver service agency - ensure that employed nutritionists are licensed to practice in the state of Tennessee (TDH Rule 0470-1)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual practitioners employed or subcontracted by D.I.D.D. must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure

that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Bureau of TennCare
Frequency of Verification:
Annually

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:
Extended State Plan Service

Service Title:
Occupational Therapy

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Occupational Therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations involving performance of activities of daily living; and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Occupational Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist. Occupational Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).
Occupational Therapy shall be provided in accordance with a treatment plan developed by a licensed occupational therapist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Occupational Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Occupational Therapy services shall require documentation of reassessment of the condition of the person supported and continuing progress of the person supported toward meeting the goals and objectives.
Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Hearing, and Language Services; Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the person supported has a record of medical justification for the two services to be provided concurrently. Occupational Therapy is not intended to replace services that would normally be provided by direct care staff.
Occupational Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Occupational Therapy shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).
The unit of reimbursement for an Occupational Therapy assessment with plan development shall be per day. The unit of reimbursement for other Occupational Therapy services shall be per 15 minutes.
Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Occupational Therapy services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Occupational Therapy unless provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Reimbursement limits:
* 1 assessmsent with plan development per month;
* 3 assessments per year per provider; and
* 1.5 hours per day for services other than assessments.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Organization
Individual	Occupational Therapist
Agency	Waiver Service Agency
Agency	Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Home Care Organization

Provider Qualifications

License *(specify):*

Home care organization - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-2)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Occupational therapy assistants must work under the supervision of a licensed occupational therapist.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify):*
Occupational therapist - Must be licensed by the Department of Health (TDH Rule 1200-8-34); Must have a valid license to practice in Tennessee (TDH Rule 1150-2)
Certificate *(specify):*
N/A
Other Standard *(specify):*
Occupational therapy assistants must work under the supervision of a licensed occupational therapist.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Waiver Service Agency
Provider Qualifications
License *(specify):*
Waiver service agency - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-2).
Certificate *(specify):*
N/A
Other Standard *(specify):*
Occupational therapy assistants must work under the supervision of a licensed occupational therapist.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD).
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System

Provider Qualifications

License *(specify):*

Waiver service agency - ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-2).

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual practitioners employed or subcontracted by D.I.D.D. must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of TennCare

Frequency of Verification:

Annually

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:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Physical therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations related to ambulation and mobility; and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Physical Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist. Physical Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care.
Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).
Physical Therapy shall be provided in accordance with a treatment plan developed by a licensed physical therapist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Physical Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Physical Therapy services shall require documentation of reassessment of the condition of the person supported and continuing progress of the person supported toward meeting the goals and objectives.
Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language, and Hearing Services; Nutrition Services, Orientation and Mobility Services for Impaired Vision; or Behavior Services, unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently. Physical Therapy is not intended to replace services that would normally be provided by direct care staff.
Physical Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Physical Therapy shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).
The unit of reimbursement for a Physical Therapy assessment with plan development shall be per day. The unit of reimbursement for other Physical Therapy services shall be per 15 minutes.
Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Physical Therapy services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Physical Therapy unless

provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursement limits:
* 1 assessment with plan development per month;
* 3 assessments per year per provider; and
* 1.5 hours per day for services other than assessments.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System
Agency	Waiver Service Agency
Individual	Physical Therapist
Agency	Home Care Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System

Provider Qualifications

License *(specify):*

Waiver service agency - ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-1)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual practitioners employed or subcontracted by D.I.D.D. must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver’s license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of TennCare

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Waiver Service Agency

Provider Qualifications

License *(specify):*

Waiver service agency - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-1)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Physical therapy assistants must work under the supervision of a licensed physical therapist.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical therapist - Must have a valid license to practice in Tennessee (TDH Rule 1150-1); Must be licensed by the Department of Health (TDH Rule 1200-8-34).

Certificate *(specify):*

N/A

Other Standard *(specify):*

Physical therapy assistants must work under the supervision of a licensed physical therapist.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD).
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Home Care Organization
Provider Qualifications
License *(specify):*
Home care organization - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-1).
Certificate *(specify):*
N/A
Other Standard *(specify):*
Physical therapy assistants must work under the supervision of a licensed physical therapist.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD).
Frequency of Verification:
Annually

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:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies and Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*

Specialized Medical Equipment and Supplies and Assistive Technology shall only mean the following:
a. An assistive device or adaptive aid or control designed for individuals with special functional needs which:
(1) Increases the ability to perform activities of daily living (e.g., adaptive eating utensils and dishware; an adaptive toothbrush); or
(2) Increases the ability to communicate with others (e.g., a hearing aid; an augmentative alternative communication device or system; an adaptive phone for individual with visual or hearing impairments); or
(3) Increases the ability to perceive or control the environment within the home (e.g., a smoke alarm with a vibrating pad or flashing light); and
b. A gait trainer; and
c. A sidelyer or similar positioning device; positioning wedges or rolls or similar positioning items; and
d. Supplies necessary for the proper functioning of specialized medical equipment or assistive technology covered within the scope of this waiver definition; and
e. Repair of specialized medical equipment or assistive technology devices covered within the scope of this waiver definition when the repair is not covered by warranty and when it is substantially less expensive to repair the equipment or device than replace it.
Specialized Medical Equipment, Supplies, and Assistive technology shall be medically necessary and shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist).
The following items are excluded from coverage:
a. Items not of direct medical or remedial benefit to the person supported;
b. Items covered by the Medicaid State Plan/TennCare Program;
c. Hearing aids and augmentative alternative communication systems for children under age 21 years;
d. Eyeglasses, frames, and lenses;
e. Elevators, stairway lifts, stair glides, platform lifts, stair-climbing devices, electric powered recliners, elevating

seats, and lift chairs;
f. Sensory processing/sensory integration equipment or other items used in sensory integration therapy (e.g., ankle weights, weighted vests or blankets, sensory/therapy balls, swings, vibrators, floor mats, balance boards, brushes, trampolines);
g. Carpets, rugs, flooring, floor pads and mats; curtains, drapes, and window treatments; furniture, lamps, and lighting;
h. Beds, mattresses, bedding, and overbed tables;
i. Air conditioning systems or units, heating systems or units; water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
j. Electrical generators, electrical service, or emergency electrical backup systems;
k. Adaptive devices for use with items specifically excluded by this waiver definition;
l. Recreational or exercise equipment and adaptive devices for such; adaptive tricycles;
m. Toys, toy equipment, and adaptive devices for toys (e.g., flash switches);
n. Radios, televisions, or related electronic audiovisual equipment (e.g., DVD players); telephone, television, or internet service; and equipment or items for education, training, or entertainment purposes;
o. Personal computers; printers, monitors, scanners, and other computer-related hardware and software (excluding equipment designed specifically and primarily to be used as an augmentative alternative communication systems for adults);
p. Orthotics;
q. Stethoscopes or blood pressure cuffs;
r. Clothing;
s. Diapers and other incontinence supplies;
t. Food, food supplements, food substitutes (including formulas), and thickening agents;
u. Prescription and over-the-counter medications; vitamins, minerals, and nutritional supplements;
v. Swimming pools, hot tubs, whirlpools and whirlpool equipment, and health club memberships;
w. Lifting and tracking systems for transfer of persons supported;
x. Supplies other than those supplies specifically required for the proper functioning of specialized medical equipment or assistive technology devices that are covered within the scope of this definition;
y. Duplicate items of specialized medical equipment or assistive technology, excluding adaptive eating utensils and dishware, to provide the person supported with a backup or spare;
z. Repair of equipment covered by warranty;
aa. Physical modification of the interior or exterior of a place of residence; and
bb. Physical modification of a motor vehicle or motor vehicle parts and services, including adaptive devices to facilitate driving.
Specialized Medical Equipment, Supplies and Assistive Technology is not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.
Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the Department's policy on submission of bids. If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for the Specialized Medical Equipment, Supplies, and Assistive Technology or the request will be denied.
Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per person supported per 2 waiver program years (calendar years).
The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per service recipient per 2 waiver program years (i.e. calendar years).

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System
Agency	Other retail or wholesale business entity
Agency	Durable Medical Equipment Supplier
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies and Assistive Technology

Provider Category:

Agency

Provider Type:

Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System

Provider Qualifications

License *(specify):*

Subcontracted entities must satisfy all applicable licensure requirements of a Durable Medical Equipment Supplier, Waiver Service Agency, or other retail or wholesale business entity.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Must honor relevant manufacturers' warranties or guarantees.

Must provide basic training on operation and maintenance of the item.

Verification of Provider Qualifications

Entity Responsible for Verification:

Bureau of TennCare

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies and Assistive Technology

Provider Category:

Agency

Provider Type:

Other retail or wholesale business entity

Provider Qualifications

License *(specify):*

Other retail or wholesale business entity - With the exception of a sole source manufacturer licensed in another state, must have a wholesale or retail business license in Tennessee (to sell equipment, supplies, etc.)

Certificate *(specify):*

N/A

Other Standard *(specify):*
Must honor relevant manufacturers' warranties or guarantees.

Must provide basic training on operation and maintenance of the item.

Repairs must be made by persons with sufficient skills and training to perform the repairs in accordance with manufacturer's standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies and Assistive Technology

Provider Category:
Agency
Provider Type:
Durable Medical Equipment Supplier
Provider Qualifications

License *(specify):*
Durable medical equipment supplier - With the exception of a sole source manufacturer licensed in another state, must have a wholesale or retail business license in Tennessee (to sell equipment, supplies, etc.)
Certificate *(specify):*
N/A
Other Standard *(specify):*
Must honor relevant manufacturers' warranties or guarantees.

Must provide basic training on operation and maintenance of the item.

Repairs must be made by persons with sufficient skills and training to perform the repairs in accordance with manufacturer's standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies and Assistive Technology

Provider Category:

Agency

Provider Type:

Waiver Service Agency

Provider Qualifications

License *(specify):*

Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as a Supported Living Service provider, an Intellectual Disability/Developmental Disability Residential Habilitation Facility, or an Intellectual Disability/Developmental Disability Adult Habilitation Day Facility.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Must honor relevant manufacturers' warranties or guarantees.

Must provide basic training on operation and maintenance of the item.

Repairs must be made by persons with sufficient skills and training to perform the repairs in accordance with manufacturer's standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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:

Extended State Plan Service

Service Title:

Speech, Language, and Hearing Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Speech, Language, and Hearing Services shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure which are provided to assess and treat functional limitations involving speech, language, or chewing/swallowing and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Speech, Language, and Hearing Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.
Services must be provided by a licensed speech language pathologist or by a licensed audiologist. Speech, Language, and Hearing Services must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Speech, Language, and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language, and Hearing assessments (i.e., assess and treat orders are not accepted).
Speech, Language, and Hearing Services shall be provided in accordance with a treatment plan developed by a licensed speech language pathologist or a licensed audiologist based on a comprehensive assessment of the needs of the person supported, and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Speech, Language, and Hearing Services to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Speech, Language, and Hearing Services shall require documentation of reassessment of the person's condition and continuing progress of the person supported toward meeting the goals and objectives.
Speech, Language, and Hearing Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the person's record of medical justification for the two services to be provided concurrently.
Speech, Language, and Hearing Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Speech, Language, and Hearing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).
The unit of reimbursement for a Speech, Language, and Hearing Services assessment with plan development shall be per day. The unit of reimbursement for other Speech, Language, and Hearing Services shall be per 15 minutes.
Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Speech, Language, and Hearing Services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Speech, Language, and Hearing Services assessments shall not be billed on the same day with other Speech, Language, and Hearing Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Speech, Language, and Hearing Services unless provided by a licensed speech language pathologist or by a licensed audiologist.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Reimbursement limits:
* 1 assessment with plan development per month;
* 3 assessments per year per provider;
* 1.5 hours per day for services other than assessment.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Organization
Agency	Waiver Service Agency
Individual	Speech language pathologist or Audiologist
Agency	Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Language, and Hearing Services

Provider Category:
Agency
Provider Type:
Home Care Organization
Provider Qualifications
License *(specify):*
Home care organization - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that therapists are licensed to practice in the state of Tennessee (TDH 1370-1).
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver’s license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD).

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Language, and Hearing Services

Provider Category:

Agency

Provider Type:

Waiver Service Agency

Provider Qualifications

License *(specify):*

Waiver service agency - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that therapists are licensed to practice in the state of Tennessee (TDH 1370-1).

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Language, and Hearing Services

Provider Category:

Individual

Provider Type:

Speech language pathologist or Audiologist

Provider Qualifications

License *(specify):*

Speech language pathologist or Audiologist - Must be licensed to practice in Tennessee (TDH Rule 1370-1); Must be licensed by the Department of Health (TDH Rule 1200-8-34)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Language, and Hearing Services

Provider Category:
Agency
Provider Type:
Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System
Provider Qualifications
License *(specify):*
Waiver service agency - ensure that therapists are licensed to practice in the state of Tennessee (TDH 1370-1)
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individual practitioners employed or subcontracted by D.I.D.D. must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Bureau of TennCare
Frequency of Verification:
Annually

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:
Other 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:
Adult Dental Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Dental Services preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection) which have dental procedure codes listed in the current TennCare Maximum Reimbursement Rate Schedule for Dental Services that is used specifically for HCBS waiver dental services; and
b. Intravenous sedation or other anesthesia services provided in the dentist's office by, and billed by, the dentist or by a nurse anesthetist or anesthesiologist who meets the waiver provider qualifications.
Orthodontic services are excluded from coverage.
Dental Services are not intended to replace services available through the Medicaid State Plan/TennCare program. All Dental Services for children enrolled in the waiver are provided through the TennCare EPSDT program. Dental Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).
Dental residents in training may provide Dental Services if they work under the direct supervision of a licensed dentist who is physically present when such services are being provided and if the licensed dentist materially participates in the provision of the Dental Services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult Dental Services shall be limited to a maximum of $5,000 per service recipient per waiver program year (i.e. calendar year), and a maximum of $7,500 per service recipient across three (3) consecutive waiver program years (i.e. calendar years).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Anesthesiologist (for dental anesthesia only)
Agency	Nurse Anesthetist (for dental anesthesia only)
Individual	Nurse Anesthetist (for dental anesthesia only)
Agency	Anesthesiologist (for dental anesthesia only)
Agency	Dentist (group or dental service agency)
Individual	Dentist
Agency	Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Dental Services

Provider Category:
Individual

Provider Type:
Anesthesiologist (for dental anesthesia only)

Provider Qualifications

License *(specify):*
Must be licensed to practice in Tennessee (TCA Title 63 Chapter 6)

Certificate *(specify):*
N/A

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Dental Services

Provider Category:
Agency

Provider Type:
Nurse Anesthetist (for dental anesthesia only)

Provider Qualifications

License *(specify):*
Must be licensed by the Department of Health (TDH Rule 1200-8-34); Must be licensed to practice in Tennessee (TDH Rules 1000-1 & 1000-2)

Certificate *(specify):*
Must be certified as a nurse anesthetist (TCA 63-7-126)

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Dental Services

Provider Category:
Individual

Provider Type:
Nurse Anesthetist (for dental anesthesia only)
Provider Qualifications
License *(specify):*
Must be licensed by the Department of Health (TDH Rule 1200-8-34); Must be licensed to practice in Tennessee (TDH Rules 1000-1 & 1000-2).
Certificate *(specify):*
Must be certified as a nurse anesthetist (TCA 63-7-126).
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Dental Services

Provider Category:
Agency
Provider Type:
Anesthesiologist (for dental anesthesia only)
Provider Qualifications
License *(specify):*
Must be licensed to practice in Tennessee (TCA Title 63 Chapter 6)
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD)

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Dental Services

Provider Category:

Agency

Provider Type:

Dentist (group or dental service agency)

Provider Qualifications

License *(specify):*

Must be licensed to practice in Tennessee (TDH Rules 0460-1 & 0460-2)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Dental Services

Provider Category:

Individual

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

Must be licensed to practice in Tennessee (TDH Rules 0460-1 & 0460-2).

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Dental Services

Provider Category:
Agency
Provider Type:
Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System
Provider Qualifications
License *(specify):*
Individual practitioners employed or subcontracted by D.I.D.D. must be licensed to practice in Tennessee (TDH Rules 0460-1 & 0460-2).
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individual practitioners employed or subcontracted by D.I.D.D. must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Bureau of TennCare
Frequency of Verification:
Annually

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:

Other 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:

Behavior Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*

Behavior Services shall mean:

a. Services to assess and ameliorate person supported behavior that jeopardizes the health and safety of the person supported, that endangers others, or that prevents the person supported from being able to successfully participate in community activities; and

b. Development, monitoring, and revision of behavior intervention strategies, including development of a Behavior Support Plan and staff instructions for caregivers who are responsible for implementation of prevention and intervention strategies; and

c. The initial training of caregivers on the appropriate implementation of behavior intervention strategies, including the Behavior Support Plan (BSP) and staff instructions.

The BSP shall be developed through the person-centered planning process in collaboration with the person receiving the services, family members, the conservator if applicable and others selected by the person who will be supporting the person receiving the services, and responsible for implementing the BSP. Therapeutic goals and objectives shall be required for persons supported receiving Behavior Services.

Behavior Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Speech, Language, and Hearing Services, unless there is documentation in the person's record of medical justification for the two services to be provided concurrently.

Behavior Services shall be provided by a Behavior Analyst face to face with the person supported except for:

(a) Completion of the Behavior Assessment Report; and

(b) Person supported-specific training of staff, except in instances when the Behavior Analyst can demonstrate appropriate interventions in real time; and

(c) Presentation of behavior information of the person supported at human rights committee meetings, behavior support committee meetings, and planning meetings related to the person supported. Reimbursement for presentation of behavior information related to the person supported at meetings shall be limited to a maximum of 5 hours per person supported per calendar year per provider.
Behavior assessments, behavior plan development, and presentations at meetings shall not be performed by Behavior Specialists. Behavior specialists are responsible for providing training, data collection and plan implementation but only behavior analysts can conduct a behavior assessment and develop the behavior support plan. Reimbursement for behavior assessments shall be limited to a maximum of 8 hours per assessment (32 qtr hour units per calendar year) with a maximum of 2 assessments per calendar year.
Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first 30 calendar days following its approval for use shall be limited to a maximum of 6 hours (24 qtr hour units per calendar year). Reimbursement shall not be made for travel time to meetings and for telephone consultations, but may be made for consultations with treating the physician or psychiatrist during an office visit when the person supported is present.
Reimbursement for presentation of person supported behavior information at human rights committee meetings, behavior support committee meetings, and person supported planning meetings shall be limited to 5 hours per provider (20 qtr hour units per calendar year).
Behavior Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program, including psychological evaluations and psychiatric diagnostic interview examinations.
Behavior Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Reimbursement limits:

* 8 hours per assessment for completion of the behavior assessment; 2 assessments per year
* 6 hours per assessment for behavior plan development and staff training during the first 30 days following its approval; 2 assessments per calendar year
* 5 hours for presentations at meetings per calendar year

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Service Agency
Agency	Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System
Individual	Behavior Analyst
Individual	Psychologist
Individual	Behavior Specialist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Behavior Services

Provider Category:
Agency
Provider Type:
Waiver Service Agency
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
A waiver service agency must ensure that employed Behavior Analysts and Behavior Specialists have been approved by DIDD.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Services

Provider Category:
Agency
Provider Type:
Department of Intellectual and Developmental Disabilities operating as an Organized Health Care Delivery System
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individual practitioners employed or subcontracted by D.I.D.D. must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Bureau of TennCare
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Services

Provider Category:
Individual
Provider Type:
Behavior Analyst
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
A Behavior Analyst must have a Master's degree in behavior analysis, psychology, special education, or related field; a minimum of 12 credit hours of undergraduate or graduate level course work in behavior analysis; and a minimum of six (6) months full-time, supervised employment (or internship/practicum) in behavior analysis under the supervision of a behavior analyst. Supervision minimally consists of face-to-face meeting for the purpose of providing feedback and technical

consultation at least once per week.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities

Frequency of Verification:

Initially upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Psychologist - Must be licensed to practice in Tennessee (TDH Rules 1180-1 and 1180-2; TCA Title 63 Chapter 11).

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Services

Provider Category:

Individual

Provider Type:

Behavior Specialist

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

A Behavior Specialist must have a Bachelor's degree from an accredited college or university in one of the behavioral sciences or in an alternative discipline, and acceptable field work and experience equivalent to one (1) year of full-time behavioral therapy or behavioral modification.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:
Initally upon enrollment.

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:
Other 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:
Behavioral Respite Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*
Behavioral Respite Services shall mean short-term behavior-oriented services for a person supported who is

experiencing a behavioral crisis that requires removal from the current residential setting in order to assist in resolving the behavioral crisis. Behavioral Respite Services providers shall also help to plan, coordinate, and prepare for the individual's transition back to his/her residential setting.
Behavioral Respite Services shall be provided in a setting staffed by individuals who have received training in the management of behavioral issues. Direct support staff must have received training in the prevention and management of crisis behavior. Behavioral Respite Services may be provided in a Medicaid-certified ICF/IID, in a licensed respite care facility, or in a home operated by a licensed residential provider. Behavioral Respite Services shall not be provided in a home where a person supported lives with family members unless such family members are also persons supported receiving Behavioral Respite Services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
The Behavioral Respite Services provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not at school, including behavioral supervision and intervention for aggressive or inappropriate behavior that jeopardizes the health and safety of the person supported or others. The Behavioral Respite Services provider shall oversee health care needs of the person supported. Behavioral Respite Services providers shall be responsible for the cost of any Day Services needed while the person supported is receiving Behavioral Respite Services.
Reimbursement for Behavioral Respite Services shall not include payment for Behavioral Respite Services provided by the spouse of a person supported. The Behavioral Respite Services provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Behavioral Respite Services provided by such individuals.
With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Behavioral Respite Services and shall be included in the reimbursement rate for such.
A person supported who is receiving Behavioral Respite Services shall not be eligible to receive Personal Assistance, Respite, or Day Services (which would duplicate services that are the responsibility of the Behavioral Respite Services provider).

Restraints shall not be used unless used in accordance with the Department's policy on use of restraints.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Behavioral Respite Services shall be limited to a maximum of 60 days per person supported per waiver (i.e., calendar) year.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed residential provider
Agency	Medicaid-certified ICF/IID
Agency	Licensed respite care facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Respite Services

Provider Category:
Agency
Provider Type:
Licensed residential provider
Provider Qualifications
License *(specify):*
Licensed Residential Provider - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Staff must meet DIDD provider qualification and training requirements. Direct support staff must have received training in the prevention and management of crisis behavior.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Respite Services

Provider Category:
Agency
Provider Type:
Medicaid-certified ICF/IID
Provider Qualifications
License *(specify):*

Medicaid-certified ICF/IID - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Institutional Habilitation Facility.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Staff must meet DIDD provider qualification and training requirements. Direct support staff must have received training in the prevention and management of crisis behavior.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Respite Services

Provider Category:
Agency
Provider Type:
Licensed respite care facility
Provider Qualifications
License *(specify):*
Licensed respite care facility - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility if an ICF/IID or as an Intellectual Disability/Developmental Disability Respite Care Services Facility if not an ICF/IID.
Certificate *(specify):*
N/A
Other Standard *(specify):*

Staff must meet DIDD provider qualification and training requirements. Direct support staff must have received training in the prevention and management of crisis behavior.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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:

Other 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:

Employment and Day Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Employment and Day Services shall mean individualized services and supports selected by the person supported, that help the person to seek employment and work in competitive integrated settings and engage in community life, based on his or her individualized needs and preferences and as reflected in the person-centered ISP, and to acquire, retain, or improve skills in the area of self-care, sensory/motor development, socialization, daily living skills, and communication, in order to pursue and achieve his or her personal employment and/or community living goals.
All individual employment and day services goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP 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 individual.
Employment and Day Services shall be provided as specified in the person-centered ISP in order to support the individual's employment and/or community living activities, or the development, retention, and improvement of skills necessary to achieve employment and/or community living goals. Day Services may be provided to persons as a separate service where permitted under service specifications described in this waiver.
Supported Employment shall be the preferred option for all persons supported that are not of retirement age, based on each person's needs and preferences, and shall be provided in accordance with the following requirements:
a. A job coach employed by the Day Services provider shall be on-site at the work location and shall support the person; or
b. The Day Services provider shall oversee the person's supported employment services including on-site supervisors, and shall have a minimum of one contact per week with the person including at least one contact per month at the work site, and shall have a job coach employed by the Day Services provider who is available on-call if needed to go to the work site.
Community-based Day Services shall support each person's full engagement in community life, based on his or her individualized needs and preferences and as reflected in the person-centered ISP, and the acquisition, retention, or improvement of skills in the area of self-care, sensory/motor development, socialization, daily living skills, communication, and social skills in order to pursue and achieve his or her personal employment and/or community living goals. This includes assisting the person to build relationships and natural supports.

Community-based Day Services are designed such that the person spends the majority of his/her time, while participating in this service, actively engaged in activities in the community. Supervision, monitoring, training, education, demonstration, or support is provided to assist with the acquisition of skills in the following areas: leisure activities and community/public events, utilizing community resources (e.g. public transportation), acquiring and maintaining employment, educational activities, hobbies, unpaid work experiences (e.g. volunteer opportunities), and maintaining contact with family and friends.
Day Services may be provided in a facility setting only when selected by a person supported who needs time-limited pre-vocational training, when such training is not available on the job site, and to persons who, through their person-centered planning process choose to participate in a facility based program in order to focus on the development of individualized and specific skills that will support them in pursuing and achieving employment and/or community living goals. Facility-based day services must allow for opportunities for all persons supported to be engaged in the broader community when appropriate and be specified in the person-centered ISP. Opportunities to transition into more integrated settings, including competitive integrated employment, will

be evaluated on at least an annual basis.

In-home Day Services are provided in the person's residence only if selected by the person supported because there is a health, behavioral, or other medical reason, or if the person has chosen retirement or is unable to participate in services outside the home.
Additional Requirements
Transportation of the person to and from the person's place of residence to the location where Day Services will be provided shall be the responsibility of the Employment or Day Services provider. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation that is needed during the time that the person is receiving Day Services shall be the responsibility of the Day Services provider, and the cost of such transportation shall be considered to be included within the Day Services reimbursement rate.
Day Services shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).
Day Services are not intended to replace services available through the Medicaid State Plan/TennCare program. Services provided by natural supports are not reimbursable and are excluded from reimbursement as part of this service.
Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. Day Services shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego. Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods.
The reimbursement for Supported Employment Day Services shall include incentive payments for vocational related specified, measurable outcomes such as:
a. A one-time payment that is made to an Employment provider when an individual obtains employment as a result of that provider's direct involvement in the job placement.
b. Stipends paid to employers that are passed through to individuals on the work site who, in addition to their regular job duties, function as a work place support for individuals served in the waiver.
c. A one-time payment that is made to an Employment provider when an individual has been employed consecutively for one year.
The reimbursement for Supported Employment Day Services shall not include incentive payments, subsidies, or unrelated vocational training expenses: such as,
a. Incentive payments that would duplicate or replace milestone payments made by Vocational Rehabilitation.
b. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
c. Payments that are passed through to users of supported employment programs.
d. Payments for vocational training that is not directly related to a person's supported employment program.
Day Services shall be limited to a maximum of 5 days per week up to a maximum of 243 days per person per calendar year. Family members who provide Day Services are required to implement services as specified in the Individual Support Plan (ISP). Reimbursement to family members shall be limited to forty (40) hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.
Day Services shall be reimbursed in accordance with the requirements set forth herein. The provider may receive the per diem reimbursement for Day Services if:
a. The person receives 6 hours of direct services, which may include, in accordance with requirements specified herein, combinations of Supported Employment, Community-based, Facility-based, and In-home Day Services.
b. The person receives at least 2 hours of Day Services and there is documentation that the person was unable to complete the full 6 hours of Day Services for reasons beyond the provider's control (e.g., sickness of the person).
Reimbursement for a combination of different Day Services (e.g., supported employment, community-based, and/or facility-based; or community-based and/or facility-based in conjunction with in-home) provided on the same day shall be made in accordance with the following:
a. If the person receives up to or in excess of 6 hours of a combination of Community-based and Facility-based Day Services, the reimbursement shall be the per diem reimbursement rate for the type of service provided for

the greatest amount of time that day.
b. If the person receives up to or in excess of 6 hours of a combination of Day services that includes Supported Employment, the reimbursement shall be the per diem reimbursement rate for Supported Employment Day Services.
c. Only in the case of a person who has chosen retirement and to encourage the person's continued participation in community life, if the person receives at least 2 hours of Community-Based Day Services in order to participate in integrated community activities of his/her choosing, and chooses to receive some or all of the remainder of the 6 hours receiving In-home Day Services, the reimbursement shall be the per diem reimbursement rate for Community-Based Day Services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Day Services shall be limited to a maximum 5 days per week up to a maximum of 243 days per service recipient per year.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual (for staff-supported employment)
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment and Day Services

Provider Category:
Individual
Provider Type:
Individual (for staff-supported employment)
Provider Qualifications
License *(specify):*
Individual (Community-based Day Services and Supported Employment)- Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Adult Habilitation Day Facility, if serving more than one individual.
Certificate *(specify):*

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment and Day Services

Provider Category:

Agency

Provider Type:

Waiver Service Agency

Provider Qualifications

License *(specify):*

Waiver service agency (Facility-based Day Services) - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Adult Habilitation Day Facility.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be

listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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:

Other 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:

Environmental Accessibility Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*

Environmental Accessibility Modifications shall only mean the following modifications to the place of residence of the person supported:

a. Physical modifications to the interior of a place of residence to increase the mobility and accessibility within the residence of the person supported;
b. Physical modifications to an existing exterior doorway of place of residence to increase the mobility and accessibility for entrance into and exit from the residence of the person supported;
c. A wheelchair ramp and modifications directly related to, and specifically required for, the construction or installation of the ramp; or as an alternative to a wheelchair ramp, a platform lift (to lift wheelchairs) and modifications directly related to, and specifically required for, the installation of a platform lift for one entrance into the residence;
d. Hand rails for exterior stairs or steps to increase the mobility and accessibility of the person supported for entrance into and exit from the residence; or
e. Replacement of glass window panes with a shatterproof or break-resistant material when medically necessary based on a history of destructive behavior by the person supported.
The following are specifically excluded from coverage:
a. Any adaptation or modification of the home which is of general utility and is not of direct medical or remedial benefit to the person supported;
b. Any adaptation or modification which is considered to be general maintenance of the residence;
c. Any physical modification to the exterior of the place of residence or lot of the person supported (e.g., driveways, sidewalks, fences, decks, patios, porches) that is not explicitly listed above as being covered;
d. Any physical modification to garage doors for entry of vehicles;
e. Any item that would be covered by the Medicaid State Plan/TennCare Program;
f. Construction of an additional room or modification of an existing room which increases the total square footage of the residence;
g. Construction of a new room within existing floor space (e.g., construction of an additional bathroom), including construction of new interior walls to subdivide existing rooms;
h. A second or additional wheelchair ramp when there is a functional wheelchair ramp for one entrance into the residence of the person supported;
i. A wheelchair ramp when there is a functional platform lift (to lift wheelchairs) for one entrance into the residence of the person supported; or a platform lift for entrance into the residence when there is a functional wheelchair ramp for one entrance into the residence;
j. Platform lifts for use inside the place of residence of the person supported;
k. Stairway lifts, stair glides, or elevators or the installation, repair, or replacement of stairway lifts, stair glides, or elevators;
l. Repair or replacement of roofing or siding;
m. Installation, repair, replacement, or painting of ceiling, walls, or floors or installation, repair, or replacement of carpet or other flooring except:
(1) When the need for such is directly related to and necessitated by another approved environmental accessibility modification (e.g., flooring or carpet repair when a doorway is widened); and
(2) When the cost of such is included in the cost of the other approved environmental accessibility modification;
n. Rugs and floor mats;
o. Furniture, lamps, beds, mattresses, bedding, and over bed tables;
p. Water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
q. Air conditioning or heating systems or units or the installation, repair, or replacement of air conditioning or heating systems or units;
r. Electrical generators; emergency electrical backup systems; batteries, or battery chargers;
s. Installation, repair, or replacement of electrical units or systems, except for the installation or replacement of electrical outlets which will be used for medical equipment;
t. Lights or lighting systems or the installation, repair, or replacement of lights or lighting systems; except for the installation or replacement of lights when the need for such is directly related to and necessary in order to complete another approved environmental accessibility modification;
u. Construction of additional exterior doorways or windows;
v. Any item that meets the waiver service definition of Specialized Medical Equipment, Supplies, and Assistive Technology;
w. Sprinklers and sprinkler systems; and
x. Costs for removing an Environmental Accessibility Modification in order to convert or otherwise restore the place of residence to its pre-existing condition (i.e., the condition before the modification was made).
Environmental Accessibility Modifications shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist).
To facilitate community transition of a Medicaid eligible person residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other institutional setting who has been determined to

qualify for HCBS waiver services upon discharge, Environmental Accessibility Modifications may be made to the place of residence of the persons supported during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. In such cases, the Environmental Accessibility Modification will not be considered complete until the date the person leaves the ICF/IID or other institutional setting and is enrolled in the waiver, and such date shall be the date of service for billing purposes.
Environmental Accessibility Modifications shall be available only for newly enrolled waiver participants, including (but not limited to) persons transitioning to the community from an institutional setting, and existing waiver participants who have recently experienced a significant loss of mobility function.
Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per person supported per three (3) consecutive waiver program years (calendar years).
Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the Department's policy on submission of bids. If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for an Environmental Accessibility Modification or the request will be denied.
If the person supported does not own the place of residence, there must be written approval from the landlord for the Environmental Accessibility Modification to be approved. Such written approval must acknowledge that the person supported will not be responsible for the costs of removing an Environmental Accessibility Modification in order to convert or otherwise restore the place of residence to its pre-existing condition.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per service recipient per three (3) consecutive waiver program years (i.e. calendar years).

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Building supplier
Individual	Individual carpenter or craftsman (including a family member)
Agency	Other retail business
Individual	Local Contractor
Agency	Waiver Service Agency
Agency	Durable Medical Equipment supplier

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:
Agency
Provider Type:
Building supplier
Provider Qualifications
License *(specify):*
Building supplier - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Certificate *(specify):*
N/A
Other Standard *(specify):*
Modifications requiring the skill of a carpenter, electrician, plumber, or other craftsman must be made by persons with sufficient skills and training to meet state and local building codes and standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:
Individual
Provider Type:
Individual carpenter or craftsman (including a family member)
Provider Qualifications
License *(specify):*
Individual carpenter or craftsman - Must be licensed in accordance with the requirements of the county or city where the service will be provided.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Modifications requiring the skill of a carpenter, electrician, plumber, or other craftsman must be made by persons with sufficient skills and training to meet state and local building codes and standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:

Agency

Provider Type:

Other retail business

Provider Qualifications

License *(specify):*

Other retail business - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Modifications requiring the skill of a carpenter, electrician, plumber, or other craftsman must be made by persons with sufficient skills and training to meet state and local building codes and standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:

Individual

Provider Type:

Local Contractor

Provider Qualifications

License *(specify):*

Local contractor - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Certificate *(specify):*

Other Standard *(specify):*

Modifications requiring the skill of a carpenter, electrician, plumber, or other craftsman must be made by persons with sufficient skills and training to meet state and local building codes and standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:

Agency

Provider Type:

Waiver Service Agency

Provider Qualifications

License *(specify):*

Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as a Supported Living Service provider or as Intellectual Disability/Developmental Disability Residential Habilitation Facility.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Modifications requiring the skill of a carpenter, electrician, plumber, or other craftsman must be made by persons with sufficient skills and training to meet state and local building codes and standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or

Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:

Agency

Provider Type:

Durable Medical Equipment supplier

Provider Qualifications

License *(specify):*

Durable medical equipment supplier - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Modifications requiring the skill of a carpenter, electrician, plumber, or other craftsman must be made by persons with sufficient skills and training to meet state and local building codes and standards.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:
Annually

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:

Other 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:

Family Model Residential Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*

Family Model Residential Support shall mean a type of residential service selected by the person supported, where he or she lives in the home of a trained caregiver who is a not family member in an “adult foster care” arrangement. A family member(s) of the persons supported shall not be reimbursed to provide Family Model Residential Support services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

In this type of shared living arrangement, the caregiver allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and family, supports each resident’s independence and full integration into the community, ensures each resident’s choice and rights, and supports each resident in a manner that 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.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP 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 individual. Family Model Residential Support includes individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside successfully in a community-based setting, living in a family environment in the home of trained caregivers other than the family of origin. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.
Family Model Residential Supports may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.
The Family Model Residential Support caregiver shall oversee the health care needs of the person supported.
The Family Model Residential Support provider agency shall not find, purchase, or lease a residence in which Family Model Residential Supports will be provided. Family Model Residential Support caregivers shall be recruited, screened, contracted, and trained prior to providing services, and monitored by the Family Model Residential Support provider agency to ensure compliance with licensing and program requirements. The Family Model Residential Support provider agency shall facilitate matching of persons supported and caregivers but shall not determine whether a caregiver chooses to participate in the program, whether a caregiver will bring a particular person supported into his or her home, or how the day-to-day activities of the home and provision of services and supports will occur. Visits, both announced and unannounced, and phone calls to the home must occur on a regular basis in order for the provider agency to ensure compliance with program requirements and the general health and safety of the person supported, but should not be so prescriptive as to instruct the provider about particular tasks to perform or ways to fulfill or not fulfill duties. Family Model Support caregivers are responsible for abiding by the quality assurance standards, outlined in the DIDD Provider Manual, which are monitored and enforced by DIDD.
A Family Model Residential Support home shall have no more than 3 residents who receive services and supports regardless of HCBS program or funding source.
The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work.
With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such.
Family Model Residential Support shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). i
Reimbursement for Family Model Residential Support shall not include payment for Family Model Residential Support provided by the spouse of a person supported. The Family Model Residential Support provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Family Model Residential Support provided by such individuals. Reimbursement for Family Model Residential Support shall not include payment made to any other individual who is a conservator, unless so permitted in the Order for Conservatorship. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling.
Family Model Residential Support may be provided out-of-state under the following circumstances,:
a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-

of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Model Residential Support

Provider Category:
Agency

Provider Type:
Waiver Service Agency

Provider Qualifications

License *(specify):*
Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Placement Service provider.

Certificate *(specify):*

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be

listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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:

Other 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:

Individual Transportation Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*

Individual Transportation Services shall mean non-emergency transport of a person supported to and from approved activities specified in the ISP. Whenever possible, immediate family members, friends who are

involved in providing supports and community agencies who can provide this service without charge should be utilized.
The following transportation services are excluded from coverage:
a. Transportation to and from medical services covered by the Medicaid State Plan/TennCare Program; and
b. Transportation of school aged children to and from school; and
c. Transportation to and from supported or competitive employment; and
d. Transportation that is the responsibility of the provider of a residential service (e.g., Residential Habilitation, Medical Residential Services, Family Model Residential Support, or Supported Living) or that is the responsibility of the provider of Day Services or Behavioral Respite Services, since it would duplicate services that are the responsibility of such providers.
Individual Transportation Services shall not be provided by the spouse of a person supported and shall not be provided by the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption, and reimbursement shall not be provided for Individual Transportation Services provided by such individuals.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to 31 days/month maximum.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Commercial transportation agency
Individual	Individual (including a family member)
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Transportation Services

Provider Category:
Agency
Provider Type:
Commercial transportation agency
Provider Qualifications
License *(specify):*
Commercial transportation agency - Must have a business license. All drivers must have a valid driver's license of appropriate type (e.g., personal, commercial) for transport in Tennessee.
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must maintain vehicle liability insurance.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Transportation Services

Provider Category:

Individual

Provider Type:

Individual (including a family member)

Provider Qualifications

License *(specify):*

Individual - Must have a valid driver's license for transport in Tennessee.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must maintain vehicle liability insurance.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of

Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Transportation Services

Provider Category:

Agency

Provider Type:

Waiver Service Agency

Provider Qualifications

License *(specify):*

Waiver service agency - All drivers must have a valid driver's license of appropriate type (e.g., personal, commercial) for transport in Tennessee.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must maintain vehicle liability insurance.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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:

Other 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:

Intensive Behavioral Residential Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*

Intensive Behavioral Residential Services is a home and community-based clinical treatment model selected by the person supported, or their representative, as appropriate, designed to meet the specific and individualized assessed needs of each person receiving the service and which supports, to the maximum extent appropriate, each resident's independence and full integration into the community; ensures, to the maximum extent appropriate, each resident's choice and rights; and 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.
This service is appropriate for individuals who have exhibited high risk behavior, placing themselves and or others in danger of harm, and whose person-centered plan reflects the positive interventions and supports used prior to this service, and less intrusive methods of meeting the need that have been tried but did not work. This service is designed to be flexible enough to respond to the changing levels of need of the person supported and the level of risk presented by the person's current behavior, with the goal of helping the person transition to a more integrated setting in the future. It is not an indefinite, long term, residential support service.
All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include, to the maximum extent appropriate and preferred by the individual, opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources. A person with high risk behavior receiving Intensive Behavioral Residential Services will have opportunities to develop a lifestyle which includes developing healthy and meaningful relationships with others.
Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.
Leadership of this service is provided by the agency Clinical Director, who is responsible for ensuring service quality and providing clinical oversight of clinical and direct support staff. Administrative functions are performed by members of the agency management team.

1. Providers are licensed and operated as a mental retardation (i.e. Intellectual Disability) Residential Habilitation Facility.
2. Each residence is no larger than a four-person home.
3. Each home may have at least one safe area that provides a room or space to which a person may (based on his or her individualized needs as reflected in the person-centered plan) retreat in order to prevent or manage an escalating behavior.
4. The service:
a. Includes an individual treatment plan which describes ongoing assessment and monitoring of the person supported and professional judgment regarding behavioral supervision, individual crisis plans, treatment objectives, and treatment planning. The individual treatment plan does not replace the federally required individual support plan. Rather, it describes in detail the person's treatment needs, etc., as described above.
b. Allows for persons supported to learn and complete activities of daily living necessary for successful social integration.
c. Has staffing ratios that are designed to be flexible in order to meet the needs of people as events occur.
d. Coordinates ancillary services that are flexible and responsive to the needs of the people supported. Ancillary services may be funded through the Managed Care Organization or the Medicaid Waiver; will vary according to the person's individual needs; and may include services such as counseling, psychotherapy, psychiatric consultation, medical, dental, and nursing and therapy services.
e. Provides behavior analyst services that are embedded within the service and are flexible and available as needed within a 24-hour period.
f. Ensures that DIDD Human Rights Committee and DIDD Behavior Support Committee approval is obtained prior to implementation of restrictive interventions, as necessary.
5. On-going safety and supervision may include any combination of the following components as determined through the person-centered planning process and documented in the person's ISP and treatment plan:

a. An intensive person-centered planning approach including determining what is important to and for the person and supporting him/her to achieve those goals identified in this process.
b. A carefully structured environment and a highly structured schedule with pre-planned activities, which the person supported participates in choosing and scheduling.
c. Proactive behavioral intervention approaches and teaching alternative strategies.
d. Learning healthy methods of expression.
e. Remote monitoring in public areas of the home.
f. Alarms to notify staff of elopement.
g. Windows designed for safety.
h. Other measures as recommended and approved.
6. Daily activities may include but are not limited to the following:
a. Supported employment when appropriate.
b. The training of self-management.
c. Training in essential life skills to attain or maintain integration in the community.

d. Habilitation, based upon individual needs and program strategies, to teach tasks that will assist the person in getting ready for a typical workday (e.g., making lunch, using public transportation, etc.)
e. Community exploration and integration.
The IBRS provider shall be responsible for the cost of Day Services needed by the person supported and any Behavior Services needed while receiving Day Services.

This service is appropriate for individuals who exhibit high risk behaviors that are dangerous or whose behaviors are so serious that when they occur, they present a potential danger to the person, staff, or the community. Examples of the behaviors that meet criteria are behaviors that have caused harm in the past (e.g., sexual predatory behavior) and have a probability of reoccurrence. These behaviors can be reasonably expected to occur in the absence of a highly structured therapeutic environment without support, supervision, and training in alternative behaviors. Specific examples include the following:
1. Directly causes serious injury of such intensity as to be life threatening or demonstrates the propensity to cause serious injury to self, others, or animals.
2. Sexually offensive behaviors with high frequency of occurrence or sexual behavior with any person who did not consent or is unable to consent to such behavior, or engaging in public displays of sexual behavior.
3. Criminal behavior.
4. Cause serious property destruction (e.g., fire setting).
Clinical Review Process
The DIDD Central Office Clinical Review Committee is responsible for reviewing and approving each person who is referred for this service. Referrals will be generated from persons supported who have been served at the highest levels of need (LON) in terms of intensity, supports, and services, yet have received minimal benefit from services at said level, and for whom Intensive Behavioral Residential Services offer a more appropriate and cost-effective service delivery model. Referrals may also be generated for persons entering the system who have issues identified that are consistent with those noted for the target population and for whom Intensive Behavioral Residential Services offer a more appropriate and cost-effective service delivery model than services the person would otherwise require. The DIDD Central Office Clinical Review Committee will review referrals from state case managers, independent support coordinators, and DIDD providers. The DIDD Central Office Clinical Review Committee is comprised of the Director of Behavioral and Psychological Services (Chair), selected clinicians, and DIDD central/regional office staff. For each person referred for this service, the committee will review the following information: intake plan, individual support plan (ISP), risk assessment, clinical assessments, and health evaluations. IBRS may be selected by the individual and offered only after alternative approaches have been tried and documented to be unsuccessful.
1. Continuing this service requires periodic (at least every six months or more frequently, as needed) evaluation by the agency Clinical Director, and approval by the DIDD Central Office Clinical Review Committee of the continued likelihood of occurrence of presenting behaviors and progress/benefit in continuing the program and the continuing need for structure and protections provided under this model. The agency Clinical Director shall submit recommendations regarding continued stay or discharge to the DIDD Central Office Clinical Review Committee, who shall make the final determination.
2. An individual may choose to no longer receive this service at any time, or otherwise shall be considered to no longer require this service if the individual has met the clinical objectives identified in the clinical plan such that the structure and protections afforded under this model are no longer appropriate, or the individual/legal representative has refused to participate in treatment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Behavioral Residential Services

Provider Category:
Agency
Provider Type:
Waiver Service Agency
Provider Qualifications
License *(specify):*
Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility.
Certificate *(specify):*
Agency providers seeking to deliver this service will be reviewed by the department's Provider Development Committee. This committee will review the provider's qualifications and performance history to determine eligibility to contract with the department and the Medicaid agency to deliver this service. Final determination will be made by the DIDD Director of Behavioral and Psychological Services or designee. The department will certify that the agency has fulfilled the requirements and is approved to deliver the service.

Providers are required to submit a program proposal that incorporates the following:
1. Evidence of eligibility for licensure or licensure as a residential habilitation facility.
2. Experience delivering specialized services for people with intellectual disabilities and high risk behaviors.
3. Resumes or vitas for local clinical and administrative leadership (e.g., agency Clinical Director, management staff).
4. Plan for training direct support professionals and management, including refresher training for maintenance of skills.
5. A description of the treatment milieu and interventions designed to enable persons supported to build social and interpersonal skills, as well as regulate or extinguish problem behaviors. Examples include the following:

a. Methods for building social and vocational competence.
b. Measures to promote the safety and well-being of the person supported, staff and the community.
c. Procedures for contacting law enforcement and/or mobile crisis.
d. Method for evaluating the need for ongoing intensive behavior services at least every three months.

e. A system for providing transition services if a person transitions to an alternate setting.
Other Standard *(specify):*
Individual practitioners employed or subcontracted by DIDD must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender

Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities
Frequency of Verification:
Annually

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:
Other 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:
Medical Residential Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*
Medical Residential Services shall mean a type of residential service selected by the person supported, encompassing the provision of direct skilled nursing services and habilitative services and supports that enable a person supported to acquire, retain, or improve skills necessary to reside in a community-based setting, and which supports each resident's independence and full integration into the community, ensures each resident's choice and rights. and 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.
All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP 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 individual..
Medical Residential Services must be medically necessary and provided in accordance with the person-centered ISP. The person supported who receives Medical Residential Services must have a medical diagnosis and treatment needs that would justify the provision of direct skilled nursing services that must be provided directly by a registered nurse or a licensed practical nurse, and such services must be needed on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits and which cannot be more cost-effectively provided through a combination of waiver services and other available services. There must be an order by a physician, physician assistant, or nurse practitioner for one or more specifically identified skilled nursing services, excluding nursing assessment or oversight, that must be provided directly by a registered nurse or by a licensed practical nurse in accordance with the Tennessee Nurse Practice Act.

The Medical Residential Services provider may elect to have the Nurse also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the individual during the period that Medical Residential Services are authorized and provided, unless such assistance cannot be safely provided by the nurse while also attending to the individual's skilled nursing needs. However, the need for Medical Residential services shall depend only on the skilled nursing needs of the individual. Medical Residential services shall be provided in an appropriately licensed Residential Habilitation or Supported Living home.
The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports, including skilled nursing services, up to 24 hours per day 7 days a week when the person supported is not at school, based on the individualized needs of each resident; however, a nurse is not required to be present in the home during those time periods when skilled nursing services are not medically necessary. One nurse can provide services to more than one person supported in the home during the same time period if it is medically appropriate to do so.
The Medical Residential Services provider shall be responsible for the cost of Day Services needed by the person supported and any skilled nursing services needed while receiving Day Services.
Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Medical Residential Services may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Medical Residential provider shall oversee the health care needs of the person supported.
A Medical Residential Services home shall have no more than 4 residents with the exception of those homes which were licensed as a Residential Habilitation Facility prior to July 1, 2000. Individuals receiving Medical Residential services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.
Medical Residential Services shall not be provided in schools or in institutional settings (e.g., inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities). Medical Residential Services shall not be provided in a home where a person supported lives with family members unless such family members are also HCBS persons supported. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
Since the Medical Residential Services provider is responsible for providing direct support services, Day Services, and other services 24 hours per day 7 days per week when the person supported is not at school, a person supported who is receiving Medical Residential Services shall not be eligible to receive Personal

Assistance, Day Services, or Respite.
Medical Residential Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.
With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such.
Reimbursement for Medical Residential Services shall not be made for room and board or for the cost of maintenance of the dwelling if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the person supported, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the person supported and who provides services to the person supported in the place of residence of the person supported. If a person supported owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported, other residents in the home, and (as applicable) live-in or other caregivers.
Reimbursement for Medical Residential Services shall not include payment made for services provided by an individual who has been appointed as the conservator of the person supported, unless so permitted in the Order for Conservatorship. Reimbursement for Medical Residential Services shall not include payment for Medical Residential Services provided by the spouse of a person supported. The Medical Residential Services provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Medical Residential Services provided by such individuals.
Medical Residential Services may be provided out-of-state under the following circumstances:
a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider)..
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Residential Services

Provider Category:
Agency
Provider Type:
Waiver Service Agency
Provider Qualifications
License *(specify):*
Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as Intellectual Disability/Developmental Disability Residential Habilitation Facility provider or a Supported Living Provider and ensure that employed nurses are licensed to practice in the state of Tennessee (TDH 1370-1).
Certificate *(specify):*

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

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:
Other 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:
Orientation and Mobility Services for Impaired Vision

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Orientation and Mobility Services for Impaired Vision shall mean services (1) to assess the orientation and mobility of a person supported to determine functional limitations resulting from severe visual impairment and (2) to provide orientation and mobility training to enable a person supported with functional limitations resulting from severe visual impairment to move with greater independence and safety in the home and community environment.
Orientation and Mobility Services for Impaired Vision shall be based on a formal assessment of the person supported and may include concept development (i.e. body image); motor development (i.e., motor skills needed for balance, posture and gait); sensory development (i.e. functioning of the various sensory systems); residual vision stimulation and training; techniques for travel (indoors and outdoors) including human guide technique, trailing, cane techniques, following directions, search techniques, utilizing landmarks, route planning, techniques for crossing streets, and use of public transportation; and instructional use of Low Vision devices.
Orientation and Mobility Services for Impaired Vision shall be provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). Orientation and Mobility Services for Impaired Vision shall be provided face to face with the person supported except for training of caregivers responsible for assisting in the mobility of the person supported and except for that portion of the assessment involving development of the plan of care. Therapeutic goals and objectives shall be required for persons supported receiving Orientation and Mobility Services for Impaired Vision. Continuing approval of Orientation and Mobility Services for Impaired Vision shall require documentation of reassessment of the condition and continuing progress of the person supported toward meeting the goals and objectives.
Orientation and Mobility Services for Impaired Vision shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Behavior Services, or Speech, Language, and Hearing Services, unless there is documentation in the record of medical justification of the person supported for the two services to be provided concurrently.
Orientation and Mobility Services for Impaired Vision shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.
The unit of reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with plan development shall be per day. The unit of reimbursement for other Orientation and Mobility Services for

Impaired Vision shall be per 15 minutes.
Reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with development of the plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Orientation and Mobility Services for Impaired Vision assessments shall not be billed on the same day with other Orientation and Mobility Services for Impaired Vision services. Orientation and Mobility Services for Impaired Vision services other than such assessments (e.g., person supported training; person supported-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of 52 hours of services per person supported per calendar year. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Orientation and Mobility Services for Impaired Vision unless provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Reimbursement limits:
* 1 assessment with plan development per month;
* 3 assessments per year per enrollee per provider; and
* 52 hours of non-assessment services per calendar year.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Service Agency
Agency	Certified orientation and mobility specialist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Orientation and Mobility Services for Impaired Vision

Provider Category:
Agency
Provider Type:
Waiver Service Agency
Provider Qualifications
License *(specify):*
Waiver service agency - must ensure that employed orientation and mobility specialists are certified by the Academy for Certification of Vision Rehabilitation
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand

instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD).

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Orientation and Mobility Services for Impaired Vision

Provider Category:

Agency

Provider Type:

Certified orientation and mobility specialist

Provider Qualifications

License *(specify):*

Certified orientation and mobility specialist - must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be

listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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:

Other 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:

Personal Assistance

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **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):*

Personal Assistance shall mean a type of service, selected by the person supported, offering individualized services and supports that enable the person to live in the community in a setting of their choice and which

supports each person's independence, rights, and full inclusion in the community; and ensures each resident's choice and rights. Personal Assistance services shall be delivered in a manner that comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP 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 individual. Supports may include of direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, meal preparation excluding cost of food, toileting and incontinence care, assistance with transfer and mobility), household chores essential to the health and safety of the person supported (e.g., washing dishes; personal laundry; general housecleaning in areas of the residence used by the person supported); budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), supervising and accompanying the person supported to medical appointments if needed, and on personal errands such as grocery shopping, picking up prescriptions, paying bills; and trips to the post office. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Personal Assistance may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

Personal Assistance is a service that is provided for the direct benefit of the person supported. It is not a service that provides direct assistance to other members of the household (e.g., preparation of meals for the family, family laundry) who are not persons supported through the waiver. Personal Assistance staff shall not provide any personal assistance services to family members of the person supported, unless such family members are also supported through the waiver residing in the same home (e.g., when 2 siblings in the home are both waiver participants).

A single staff person may provide Personal Assistance services to more than one individual residing in the same home at the same time, provided each person's needs can be safely and appropriately met. When Personal Assistance is provided as a shared service for 2 or more family members residing in the same home (regardless of funding source), the total number of units of shared Personal Assistance shall be apportioned based on an assessment of individual need and the apportioned amount included in the ISP for each waiver participant, as applicable. Only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported. Documentation of service delivery must be kept for each person supported and shall reflect the total number of shared units of service provided, and the tasks performed/assistance provided for that individual.

Personal Assistance is often delivered in the place of residence of the person supported; however, it may be provided outside the person supported home in community-based settings where the Personal Assistance provider accompanies the person supported to perform tasks and functions in accordance with the approved service definition and as specified in the person-centered ISP. Personal Assistance does not include routine provision of Personal Assistance services in an area outside the person's local community of residence. On an infrequent and exceptional basis and in accordance with the approved person-centered ISP, Personal Assistance services may be provided in an area outside the person's local community of residence.

Personal Assistance may be provided in the home or community; however, it shall not be provided in schools for school-age children, to replace personal assistance or similar services required to be covered by schools, to transport or otherwise take children to or from school, or to replace services available through the Medicaid State Plan/TennCare Program. Personal Assistance services shall not be provided in the home of the Personal Assistant, except (1) when the person supported lives in the home with the Personal Assistant or (2) on an infrequent and exceptional basis when the person supported is attending a special event (e.g., a party) that is held in the home of the Personal Assistant. Services provided in the Personal Assistant's home must be specified and in accordance with the approved person-centered ISP.

Personal Assistance may be provided during the day or night, as specified in the person-centered ISP. A person supported who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Individuals receiving Personal Assistance services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

Personal Assistant Services shall not be provided during the same time period that the person supported is receiving Day Services, Respite Services, services under a 504 Plan or Individual Education Program (IEP), is

being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego.
This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Personal Assistance shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home) when the facility's licensure category requires the provision of personal assistance or personal care services.
Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the person supported. The Personal Assistant shall not be the spouse of a person supported and shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Personal Assistance provided by such individuals. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.
Family members are required to implement services as specified in the person-centered ISP. Reimbursement to family members shall be limited to forty hours per week per family member. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.
The unit of reimbursement for Personal Assistance services shall be 15 minutes.
The Personal Assistance provider is not obligated to provide transportation for the person supported as part of the Personal Assistance service; however, a Personal Assistance provider who is also an Individual Transportation Services provider may bill for Individual Transportation Services for transport of the person supported into the community.
Personal Assistance may be provided out-of-state under the following circumstances:
a. Out-of-state services shall be subject to the same monthly limitation as Personal Assistance services provided in-state and in addition, are limited to a maximum of 14 days of service per person supported per waiver program year (calendar year), regardless of the number of hours of service provided each day.
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal Assistance services shall be limited to a maximum of 860 units (215 hours) per waiver participant per month. Out of state Personal Assistance services are subject to the same monthly limitation, and in addition, are limited to a maximum of 14 days per waiver participant per waiver program year (i.e. calendar year).

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Organization

Agency	**Waiver service agency**
Individual	**Individual (as permitted by federal regulations)**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Assistance

Provider Category:
Agency
Provider Type:
Home Care Organization
Provider Qualifications
License *(specify):*
Home care organization - Must be licensed as a home care organization in Tennessee (TDH Rule 1200-8-8-.01)
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Assistance

Provider Category:
Agency
Provider Type:
Waiver service agency
Provider Qualifications
License *(specify):*
Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as a Personal Assistance Service provider.
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Assistance

Provider Category:
Individual
Provider Type:
Individual (as permitted by federal regulations)
Provider Qualifications
License *(specify):*
Individual - Must be licensed by the Department of Intellectual and Developmental Disabilities as a Personal Assistance Service provider, if more than one individual is served.
Certificate *(specify):*
N/A

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

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:
Other 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:
Personal Emergency Response Systems

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
A Personal Emergency Response System shall mean a stationary or portable electronic device used in the place of residence of the person supported which enables the person supported to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.
A Personal Emergency Response System shall consist of installation and testing of the Personal Emergency Response System as well as monthly monitoring performed by a response center.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Monitoring is limited to 1 unit/month (12 units/calendar year) maximum.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Agency
Provider Type:
Personal Emergency Response System Vendor
Provider Qualifications
License *(specify):*
Must have a valid business license in Tennessee.
Certificate *(specify):*
N/A
Other Standard *(specify):*
All devices must meet Federal Communications Commission, Underwriters' Laboratory, or other

equivalent standards and must be monitored by trained professionals.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

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:

Other 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:

Semi Independent Living

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Semi-Independent Living Services (SILS) shall mean services selected by the person supported that include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene, interpersonal and social skills building, and other activities needed to maintain and improve the capacity of an individual with an intellectual disability to live in the community, and which supports the person's independence and full integration into the community, ensures the person's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual's specific assessed need and set forth in the person-centered Individual Support Plan (ISP).
The service also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The SILS provider shall oversee the health care needs of the person supported.
This service is appropriate for people who need intermittent or limited support to remain in their own home and do not require staff that lives on-site. However, access to emergency supports as needed from the provider on a 24/7 basis is an essential component of this residential service and is what differentiates it from Personal Assistance services.
Individuals receiving SILS may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home. No more than 3 persons receiving services will be permitted per residence. All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP 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 individual. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.
The Circle of Support must consider the person's level of independence and safety prior to establishing a semi-independent living arrangement. Safety considerations must be reviewed at least annually (and more often should a change of needs or circumstances warrant). Consideration regarding the use of a Personal Emergency Response System should be given when appropriate. The ISP must reflect the routine supports that will be provided by residential staff.
The person may choose to live with one or two other persons supported and share expenses or to live alone as long as sufficient financial resources are available to do so.
Reimbursement for SILS shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person(s) supported and other residents in the home (if applicable).
A person who is receiving SILS shall not be eligible to receive Personal Assistance, Respite or Transportation as separate services. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of SILS and shall be included in the reimbursement rate for such.
The SILS provider shall not own the person's place of residence or be a co-signer of a lease on the person's place of residence unless the provider signs a written agreement with the person that states that the person will not be required to move if the primary reason is because the person desires to change to a different provider. The SILS

provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person to move if the person desires to change to a different provider.
SILS shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/IID). A family member(s) of the person supported shall not be reimbursed to provide SILS. SILS shall not be provided in a home where a person supported lives with family members unless such family members are also persons receiving waiver services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
On a case-by-case basis, the DIDD Commissioner or designee may authorize SILS for a person supported who resides with his or her spouse and or minor children.
SILS shall not be provided out-of-state.
A minimum of two face-to-face direct service visits in the home per week are required for each person receiving SILS. However, providers delivering this service are required to implement provisions for availability of provider staff on a 24 hour basis in case emergency supports are needed.
SILS providers are required to be licensed as Mental Retardation (i.e., Intellectual Disabilities) Semi-Independent Living Providers.
For individuals who are transitioning from a 24-hour residential waiver service supports into SILS and need additional hours of support during the transition period, providers will be reimbursed at a transition period rate, per the waiver max fee schedule, for a period of no more than 30 days from the date of transition.
For persons supported successfully transitioned from a 24-hour residential waiver service into Semi-Independent Living, a one-time per person “Transition to Independent Living Payment” will be made to the provider after the person supported has spent 6 consecutive months in SIL, so long as the person is still in SIL at the time of billing and is expected to continue living successfully in this setting. The “Transition to Independent Living Payment” will not count against a person’s individual cost neutrality cap, but will be included in all federally required demonstrations of waiver cost neutrality.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Semi Independent Living

Provider Category:
Agency
Provider Type:
Waiver Service Agency
Provider Qualifications
License *(specify):*

Must be licensed by the Department of Intellectual and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation (i.e. Intellectual Disability) Semi-Independent Living Provider.
Certificate *(specify):*
N/A
Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities
Frequency of Verification:
Annually

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:
Other 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:
Supported Living

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Supported Living shall mean a type of residential service selected by the person supported having individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a home that is owned or leased by the residents and which supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and 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.
All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP 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 individual. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation (excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.
Supported Living may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Supported Living provider shall oversee the health care needs of the person supported.
The Supported Living provider shall not own the place of residence of the person supported or be a co-signer of a lease on the place of residence of the person supported unless the Supported Living provider signs a written agreement with the person supported that states that the person supported will not be required to move if the primary reason is because the person supported desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person supported to move if the Supported Living provider changes. The person supported (or the parent, guardian, or conservator acting on behalf of the person supported) shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.
A Supported Living home shall have no more than 3 residents including the person supported. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must pass a home inspection approved by the State Medicaid Agency.
The Supported Living provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not receiving Day Services, is not otherwise engaged with natural supports, or is not at school or work. Thus, a person supported who is receiving Supported Living shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Supported Living provider).
Supported Living shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)). Supported Living shall not be provided in a home where a person supported lives with family members unless such family members also receive Supported Living

services, or by special exception when the family member is a minor child living with a parent receiving services or spouse of a person receiving services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
In Supported Living companion model, family and friends of the companion staff may only reside in the home of the person supported when approved by the person supported or his/her conservator. Such approval shall be documented in the person-centered ISP. Individuals receiving Supported Living services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.
Supported Living shall not be covered for persons supported under age 18 years.
With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such.
Reimbursement for Supported Living shall not include payment for Supported Living provided by the spouse of a person supported. The Supported Living provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Supported Living provided by such individuals.
Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the person supported and who provides services to the person supported in the home of the person supported. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported, other residents in the home, and (as applicable) live-in or other caregivers. For Supported Living services in a companion model home, all U.S. Department of Labor, Wage and Hour Division rules shall be applied to live-in caregivers.
Supported Living may be provided out-of-state under the following circumstances:
a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Individual	**Individual**
Agency	**Waiver Service Agency**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Living

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
Individual - Must be licensed by the Department of Intellectual and Developmental Disabilities as a Supported Living Service provider, if serving more than one person.
Certificate *(specify):*

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supported Living

Provider Category:
Agency
Provider Type:
Waiver Service Agency
Provider Qualifications
License *(specify):*
Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as a Supported Living Service provider.
Certificate *(specify):*

Other Standard *(specify):*
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Intellectual and Developmental Disabilities (DIDD)
Frequency of Verification:
Annually

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:
Other 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:
Transitional Case Management

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

- ○ **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):*
Transitional Case Management shall mean case management services provided for the purpose of community transition of a Medicaid eligible person residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other institutional setting who has been determined to qualify for HCBS waiver services upon discharge during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. Transitional Case Management shall assist the person supported in identifying, selecting, and obtaining both paid services and natural supports to enhance the independence, integration in the community, and productivity of the person supported, as specified in the transitional plan of care. Transitional Case Management shall be person-centered and shall include, but not be limited to, ongoing assessment of the strengths and needs of the person supported; development, evaluation, and revision of the transitional plan of care; assistance with the selection of service providers; provision of general education about the waiver program, including person supported rights and responsibilities; and monitoring implementation of the transitional plan of care. Transitional case management shall include at least one face-to-face contact with the person supported per calendar month. The date the person leaves the ICF/IID or other institutional setting and is enrolled in the waiver shall be the date of service for billing purposes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to the last 180 consecutive days of the person s institutional stay prior to being discharged and enrolled in the waiver.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Agency	**ISC Service Agency**
Individual	**Independent Support Coordinator**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:
Agency
Provider Type:
ISC Service Agency
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
The Support Coordinator must have:

1. A Bachelor's degree from an accredited college or university in a human services field; or

2. A Bachelor's degree from an accredited college or university in a non-related field and one year of relevant experience; or

3. Associate degree plus two (2) years of relevant experience; or

4. Four (4) years of relevant experience.

Relevant experience means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.

Support coordinators who do not have a Bachelor’s degree in a human services field must be supervised by someone who does meet that qualification.

Support Coordinators must successfully complete required pre-service training courses as well as periodic in-service training and any other any re-training required to maintain approval to be a Support Coordinator.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver’s license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender

Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:

Independent Support Coordinator

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The Support Coordinator must have:

1. A Bachelor's degree from an accredited college or university in a human services field; or

2. A Bachelor's degree from an accredited college or university in a non-related field and one year of relevant experience; or

3. Associate degree plus two (2) years of relevant experience; or

4. Four (4) years of relevant experience.

Relevant experience means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.

Support coordinators who do not have a Bachelor’s degree in a human services field must be supervised by someone who does meet that qualification.

Support Coordinators must successfully complete required pre-service training courses as well as periodic in-service training and any other any re-training required to maintain approval to be a Support Coordinator.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Intellectual and Developmental Disabilities (DIDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

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

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

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.
A statewide criminal background check is performed by the Tennessee Bureau of Investigation or a Tennessee-licensed private investigation company. If the staff person has resided in Tennessee for one year or less, a nationwide criminal background check is required in accordance with DIDD requirements.
During Qualified Provider Reviews conducted by the Department of Intellectual and Developmental Disabilities (DIDD), the provider's personnel files are reviewed to ensure that there is documentation that the mandatory background and registry checks have been conducted on potential staff who will have direct contact with or direct responsibility for the person supported.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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.
The process for ensuring that these checks have been completed appropriately and timely is part of the quality assurance survey process set forth in the waiver application (see performance measure a.i.a.6.). During the provider performance review, determination is made as to the provider's compliance with the above requirements through a check of personnel records for all new employees and employees with a change in job responsibilities to include direct care for a person supported (existing employees would have already been verified). Should there be any deficiencies in a provider's performance within this area, the provider is required to correct the deficiencies within 30 calendar days of discovery. DIDD collects data regarding compliance with these requirements and remediation of deficiencies, and reports monthly to TennCare in performance measure compliance reports. Furthermore, DIDD conducts monthly checks of the Office of Inspector General List of Excluded Individuals and Entities for all providers and sends the monthly reports directly to TennCare Program Integrity.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Intermediate Care Facility for individuals with Intellectual Disabilities	
Licensed Residential Provider	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Intermediate Care Facility for individuals with Intellectual Disabilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Medical Residential Services	☐
Environmental Accessibility Modifications	☐
Adult Dental Services	☐
Behavior Services	☐
Personal Assistance	☐
Employment and Day Services	☐
Respite	☑
Personal Emergency Response Systems	☐
Support Coordination	☐
Specialized Medical Equipment and Supplies and Assistive Technology	☐
Transitional Case Management	☐
Speech, Language, and Hearing Services	☐
Nutrition Services	☐
Residential Habilitation	☐
Semi Independent Living	☐

Supported Living	☐
Individual Transportation Services	☐
Physical Therapy	☐
Occupational Therapy	☐
Intensive Behavioral Residential Services	☐
Orientation and Mobility Services for Impaired Vision	☐
Behavioral Respite Services	☑
Nursing Services	☐
Family Model Residential Support	☐

Facility Capacity Limit:

N/A

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Residential Provider

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Medical Residential Services	☑
Environmental Accessibility Modifications	☐
Adult Dental Services	☐
Behavior Services	☐
Personal Assistance	☐
Employment and Day Services	☐
Respite	☑
Personal Emergency Response Systems	☐
Support Coordination	☐
Specialized Medical Equipment and Supplies and Assistive Technology	☐
Transitional Case Management	☐
Speech, Language, and Hearing Services	☐
Nutrition Services	☐
Residential Habilitation	☑
Semi Independent Living	☐
Supported Living	☐
Individual Transportation Services	☐
Physical Therapy	☐
Occupational Therapy	☐
Intensive Behavioral Residential Services	☐
Orientation and Mobility Services for Impaired Vision	☐
Behavioral Respite Services	☑
Nursing Services	☐
Family Model Residential Support	☐

Facility Capacity Limit:

4, but some greater than 4 were grandfathered in.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑

Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ○ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Family members may be employed by a provider agency selected by the person supported to provide waiver services, including Personal Assistance. Family members who provide Personal Assistance or any other waiver service as permitted in accordance with the waiver service definition must meet the same standards as staff who are unrelated to the person supported and shall not be the spouse and shall not be the parent or custodial grandparent if the person supported is a minor.
This requirement includes implementing services as specified in the ISP. Reimbursement to family members shall be limited to forty hours per week per family member and shall not supplant natural supports that would

otherwise be provided at no cost to the Medicaid program.. The person supported, working with his/her Circle of Support, as desired and appropriate,, is responsible for determining if the use of family members to deliver his/her paid care is the best choice
Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order of Conservatorship [T.C.A.1200-13-1-.25(3)l].
The state makes such allowances for the best interest of the person supported. Payment to family members is intended to promote a more family-oriented residential environment, allowing the person supported to stay in their own home. This promotes family involvement in the life of the person, with the intent to strengthen the person's family unit.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A spouse or the parent or custodial grandparent or guardian of a minor child shall not be employed and paid by a provider agency to provide waiver services. In Tennessee, "guardian" refers to the legally responsible person for a minor.
Family members employed by a provider agency who provide Personal Assistance or any other waiver service as permitted in accordance with the waiver service definition must meet the same standards as providers who are unrelated to the person supported and shall not be the spouse and shall not be the person supported parent or custodial grandparent if the person supported is a minor.
Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order of Conservatorship [T.C.A. 1200-13-1.25(3)1].
Such service providers are also subject to review by both DIDD and the State Medicaid Agency reviewers. Family members who are providers are expected to abide by all applicable state and federal guidelines, as well as all policies administered by either DIDD or the State Medicaid Agency.

- ○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

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 be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
• Any waiver service provider who is responsible for transporting a person supported shall ensure that the driver has a valid driver's license and current automobile liability insurance.
• Staff who have direct contact with or direct responsibility for the person supported shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities.
• 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.
• Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
• All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.10. # and % of newly employed (or reassigned) direct support staff delivering services to waiver participants who are able to read, write, and communicate in English. % = # of newly employed (or reassigned) direct support staff who are able to read, write, and communicate in English / total # of newly employed (or

reassigned) direct support staff serving waiver participants in the QP sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.8. # and % of newly employed/reassigned DSS serving waiver participants who had Tennessee felony checks completed prior to, but no more than 30 days in advance of employment or a change in assignment to direct support. % = # of newly employed/reassigned DSS with timely Tennessee felony Registry checks/total number of newly employed/reassigned DSS serving waiver participants in the QP sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency

		providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.7. # and % of newly employed/reassigned DSS serving waiver participants with Sexual Offender Registry checks completed prior to, but no more than 30 days in advance of employment or reassignment to direct support. % = # of newly employed/reassigned DSS with timely Sexual Offender Registry checks/total number of newly employed/reassigned DSS serving waiver participants in the QP sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.6. # and % of newly employed (or reassigned) direct support staff serving waiver participants who had Abuse Registry checks completed prior to, but no more than 30 days in advance of employment or a change in assignment to direct support. % = # of newly employed/reassigned DSS with timely Abuse Registry checks/total number of newly employed DSS serving waiver participants in the QP sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.5. # and % of newly employed (or reassigned) direct support staff serving waiver participants who passed background checks prior to, but no more than 30 days in advance of, employment or a change in assignment to direct support. % = # of newly employed/reassigned DSS with timely background checks/total number of newly employed (or reassigned) DSS serving waiver participants in the QP sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.4. Number and percentage of providers who continue to meet applicable licensure/certification following initial enrollment. Percentage = number of providers who maintained licensure/certification / total number of providers surveyed for which licensure/certification is required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database The Bureau of TennCare will collect data pertaining to D.I.D.D. operating as an Organized Health Care Delivery System.

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of proficient agency providers; annual review of representative sample (confidence interval = +/- 5% of Independent providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

a.i.a.1. # & % of approved new providers who met all applicable qualifications (e.g. licensure/certification, background and registry checks, references) prior to service provision. % = # of newly approved providers meeting all qualifications / total # of newly approved providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Provider Enrollment Database The Bureau of TennCare will collect data pertaining to D.I.D.D. operating as an Organized Health Care Delivery System.

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.11. # and % of newly employed (or reassigned) direct support staff who transport waiver participants and who had a current driver's license. Percentage = newly employed (or reassigned) direct support staff who transport waiver participants and had a current driver's license / total number of newly employed (or reassigned) direct support staff serving waiver participants in the QP sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.16 Newly employed (or reassigned) direct support staff serving waiver participants (persons supported) with federal List of Excluded Individuals/Entities (LEIE) checks completed prior to, but no more than 30 calendar days in advance of employment, or a change in assignment to direct support.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LEIE Report to TennCare Program Integrity

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe

		Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.b.1. Number and percentage of non-licensed/non-certified providers who met waiver provider qualifications. Percentage = number of unlicensed/non-certified providers who met requirements / total number of unlicensed/non-certified providers in the QP sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of proficient agency providers; annual review of respresentative sample (confidence interval = +/- 5% of independent providers)
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.1. # and % of newly employed (or reassigned) direct support staff delivering services to waiver participants who completed required training prior to direct service delivery. Percentage = # of newly employed (or reassigned) direct support staff who completed required training / total number of newly employed (or reassigned) direct support staff serving waiver participants in the QP sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Qualified Provider Review Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: College of Direct Support	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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.
Note: The State added a.i.a.16 to reflect the ongoing requirement that Newly employed (or reassigned) direct support staff serving waiver participants (persons supported) with federal List of Excluded Individuals/Entities (LEIE) checks completed prior to, but no more than 30 calendar days in advance of employment, or a change in assignment to direct support.

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. Providers who achieve exceptional or proficient Provider Performance Survey scores, who achieve substantial compliance in Domain 3: Safety and Security, who have a substantiated rate of investigation which is less than 10 per 100, and who have no suspicious deaths since the previous provider

performance survey qualify for reduction in the frequency (i.e., every two years) of the Provider Performance Survey. A representative sample of independent providers (e.g., physical therapists, occupational therapists, speech language pathologists, audiologists, nurses, nutritionists, and behavior service providers) who do not employ any additional staff (i.e., the provider consists of one person) will be surveyed/reviewed annually.

Performance Measure a.i.a.5.: Tennessee Code Annotated (33-2-1201) states: "Each organization shall have a criminal background check performed on each employee whose responsibilities include direct contact with or direct responsibility for service recipients."

b. 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.1. through a.i.a.3.: Providers who do not meet the requirements specified in these performance measures will not be allowed to sign a Provider Agreement, enroll in the DIDD and/or TennCare MMIS claims processing systems, or receive payment for services rendered. Applications that do not meet requirements will be denied. Written denials of provider applications will indicate which requirements have not been met and advise that the provider may reapply for consideration with additional documentation that such requirements have been met.

Performance Measure a.i.a.4.: When DIDD identifies that an existing provider has not maintained required licensure/certification, DIDD will notify 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 Provider Agreement will be terminated unless proof of licensure/certification is submitted to DIDD within 30 days of the date the issue was identified. The provider will not be eligible for payment of claims until licensure/certification issues are resolved.

Performance Measures a.i.a.5. through a.i.a.8.: DIDD will review a sample of provider agency staff personnel records during Qualified Provider Reviews. For individual direct support staff who did not have required background/registry checks at the time of the Qualified Provider Review, DIDD will request that the background and/or registry check be initiated during the review. Designated DIDD Regional Office staff will be responsible for verifying that the background/registry check was obtained and reviewing the results. If staff did not pass the background/registry check, DIDD will require the provider agency to take appropriate personnel action(s), and designated DIDD Regional Office staff will verify that the provider took appropriate action within 30 days of the provider's receipt of the completed background check. For staff in the sample who commit a serious criminal offense during the course of employment, DIDD will determine if the provider agency took appropriate action, or if action is pending, will verify that the provider took appropriate action within 30 days of discovery. Failure to obtain background or registry checks 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.

Performance Measure a.i.a.9.through a.i.a.11.: DIDD will review a sample of provider agency staff personnel records during Qualified Provider Reviews. For individual direct support staff who did not meet waiver general qualifications, DIDD will notify the provider and request that the provider take appropriate personnel action, which may include termination of the employee, ensuring that the employee acquires the skills needed to meet general requirements, or reassignment to a non-contact position. Designated DIDD Regional Office staff will be responsible for verifying that the appropriate actions were taken within 30 days of discovery.

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.

Individual Remediation Data Aggregation: DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible DIDD staff and back-up staff are identified for each task. Designated DIDD Central Office staff compile the data collected and entered by regional and central office staff into DIDD databases to create data files that are posted for TennCare analysis

and aggregation. In addition, DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and

methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

At the time of this waiver submission, per the Transition Plan, Part C, HCBS providers are currently completing the self-assessment and where applicable, provider specific transition plan development processes. The deadline for completion of these activities is March 31, 2015. Designated reviewers must complete validation of all provider self-assessments and transition plans by September 30, 2015. The State will report to CMS the current status of the State's compliance with HCB Setting Rules on all providers by December 31, 2015.

The State shall require, prior to enrollment of new HCBS providers, that the provider is assessed to confirm that settings will comport 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 Individual Support Plan (ISP).

On an ongoing basis, each provider will be assessed to ensure that services are being delivered to all service persons supported in a manner that comports with the HCBS settings rule. In addition, 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Support Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The Independent Support Coordinator (ISC) must have:
1. A Bachelor's degree from an accredited college or university in a human services field; or
2. A Bachelor's degree from an accredited college or university in a non-related field and one (1) year of relevant experience; or
3. Associate degree plus two (2) years of relevant experience; or
4. High School diploma or general educational development (GED) certificate plus four (4) years of relevant experience.

Relevant experience as it relates to Independent Support Coordinators means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
Independent Support Coordinators who do not have a Bachelor's degree in a human services field must be supervised by someone who does meet that qualification.
Support coordination provider agencies are required to ensure that persons employed to render support coordination services receive effective guidance, mentoring, and training, including all training required by DIDD. Effective training must include opportunities to practice support coordination duties in a manner that promotes development and mastery of essential job skills.
The intent of providing independent support coordination is to ensure that planning and coordination of services is conflict-free. Thus, providers of independent support coordination services are prohibited from providing both support coordination and other direct waiver services. Support coordination providers must maintain an office in each grand region where services are provided.

Support Coordination must be conducted in a manner that ensures person-centered planning processes and practices are followed pursuant to all applicable state and federal regulations.

- [ ] **Social Worker**

Specify qualifications:

- [ ] **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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. 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 ISP, and will help to arrange for such supports, and actively engage the person and others he designates in the development of the initial ISP. Intake staff will review the PreAdmission Evaluation (PAE) and the initial ISP 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 the waiver, all persons supported have an assigned Independent Support Coordinator who is responsible for facilitating the development of the ISP; 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 ISP and the person's health and welfare.

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 (ISP).

Appendix D: Participant-Centered Planning and Service Delivery

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):

Independent Support Coordinators (ISCs) assist persons supported in identifying their needs and preferences and selecting, obtaining and coordinating services using paid and natural supports. The ISC, in collaboration with the person supported, the person supported authorized representative (if applicable), other persons specified by the person supported (this may include family members, friends, and paid service providers selected by the person) convene at time and location convenient to the person supported, in a formal Planning Meeting to discuss and finalize the ISP which is the person-centered ISP. Prior to the development of the ISP, waiver services are provided in accordance with the initial ISP included in the approved ICF/IID PAE. The time period for development of the ISP after enrollment into the waiver program is 60 calendar days.

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
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 that reflects their preferences, choices, and desired outcomes provide for:

a. An assessment of the individual’s status, adaptive functioning, and service needs through the administration of a uniform assessment instrument (such as the Supports Intensity Scale);

b. The identification of individual risk factors through the administration of the Risk Issues Identification Tool, and identification of strategies to mitigate risks, including documentation of the individual’s understanding of the risks and mitigation strategies, including documentation that those strategies have been clearly explained;

c. Additional assessments, where appropriate, by health care professionals (e.g., occupational or physical therapists, behavior analysts, etc.);

d. The identification of personal outcomes, support goals, supports and services needed, information about the person's current situation, what is important to the person supported, and changes desired in the person's life (e.g., home, work, relationships, community membership, health and wellness). (Information for the ISP 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.);

e. 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; and
f. Waiver and other services are coordinated by the ISC through the development and implementation of the ISP. The ISP 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 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 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.

A formal Planning Meeting which is convened to finalize the ISP.

The ISP 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 the ISC is accomplished through monthly face-to-face monitoring visits. When an individual is residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. The frequency of face-to-face visits shall be specified in the ISP and may occur more frequently when needed. Completion of a monthly status review of the ISP will be documented for each individual per service received.

The ISP will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service regardless of funding source. 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.

Appendix D: Participant-Centered Planning and Service Delivery

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 Risk Issues Identification Tool is administered as part of the process for developing the person's ISP. 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.

In addition, the State has a system in place for assuring emergency backup and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While the state may define and plan for emergencies on an individual basis, the state also must have system procedures in place.

As a result of the administration of the Risk Issues Identification Tool, situations will be identified when access to emergency backup services could be required and appropriate person-centered strategies will delineate how emergency backup services will be triggered and responsibilities for ensuring that such services are furnished. As appropriate, strategies will identify informal (unpaid) supports that could assist in meeting emergency backup needs.

As a third tier of emergency backup services, regional office personnel or staff from a state Developmental Center will directly furnish the emergency backup services.

Appendix D: Participant-Centered Planning and Service Delivery

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 a 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). 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 Bureau of TennCare 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 assures 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 ISP. The ISC will provide information about selecting from among qualified providers of the waiver services in the ISP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The initial ISP must be submitted to TennCare as part of the PreAdmission Evaluation (PAE or level of care) application. All initial ISPs are reviewed and approved as part of the PAE. While subsequent plans of care are reviewed and approved by DIDD, they remain subject to the review and approval of TennCare at TennCare's discretion. TennCare reviews the adequacy and appropriateness of ISP through the quality assurance process set forth in the waiver application (see Appendix D). In addition, TennCare regularly reviews ISPs as part of the utilization review process which is described in Appendix I.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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 and if the services described in the plan are meeting the person's needs. Monitoring by ISCs is accomplished through completing a minimum of one face-to-face visit each month and by completing a Monthly Status Review of the ISP across all service delivery environments. If the person is receiving residential services, one face-to-face per quarter (i.e. once every 3 months) must be conducted in the person's place of residence. The frequency of monitoring visits shall be specified in the ISP and may be provided more frequently as needed. Information is gathered using standardized processes and tools.
The ISC reports issues identified to management staff from the appropriate provider agencies. DIDD Regional Office management staff may assist in achieving resolution when timely provider response does not occur.

All individuals who receive supports and services through DIDD are required to have an annual risk assessment. This assessment is a component of the planning process intended to identify potential risks and create an environment that establishes appropriate safeguards without limiting personal experiences. Risk management is accomplished through risk assessment and identification of risk factors, risk analysis and planning, ongoing evaluation of the effectiveness of risk management strategies, and staff training and re-training as appropriate.

The success of individual strategies to ameliorate individual risks identified through risk assessment are evaluated by the person supported, their families and significant others, providers, and the ISC as part of on-going planning for and monitoring of services.

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.

b. **Monitoring Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.4. # and % of consumer satisfaction survey respondents who reported that the things important to them were addressed in their Individual Support Plan. % = # of survey respondents who reported that the things important to them were addressed in their ISP / total # of waiver participants in the sample who responded to this survey question.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDS Participant Satisfaction Survey

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.2. Number and Percentage of waiver participants who have Individual Support Plans with measureable action steps applicable to each of the outcomes specified. Percentage = number of waiver participants who have ISPs with measureable action steps for each outcome/ total number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Individual Record Review

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.2. Number and Percentage of waiver participants whose Individual Support Plans were revised, as applicable, by the ISC/case manager to address their changing needs. Percentage = Number of participants' Individual Support Plans that were revised, as applicable/ total number of waiver participants in the sample who required a revised ISP due to changing needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDS Individual Record Review

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.c.1. Number and Percentage of Individual Support Plans reviewed and revised (as needed) before the annual review date. Percentage = Number of waiver participants whose Individual Support Plans were reviewed/revised before the annual review date / total number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDS Individual Record Review

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.d.4. Number and Percentage of waiver participants who received services for the duration specified in the approved Individual Support Plan. Percentage = number of waiver participants receiving services for the duration specified in the ISP/ total number of waiver participants in the sample less TennCare approved and documented exceptions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDS Individual Record Reviews

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.d.3. Number and Percentage of waiver participants who received services at the frequency specified in the approved Individual Support Plan. Percentage = number of waiver participants receiving services at the frequency specified in the ISP/ total number of waiver participants in the sample less TennCare approved

and documented exceptions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDS Individual Record Review

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5 +/- %5
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

	☐ **Other** Specify:

Performance Measure:
a.i.d.2. Number and Percentage of waiver participants who received the amount of service specified in the approved Individual Support Plan. Percent = number of waiver participants receiving the amount of services in the ISP/ total number of waiver participants in the sample less TennCare approved and documented exceptions.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.e.5. Number and Percentage of waiver participants whose records contained documentation that the service recipient or guardian/conservator, as applicable, was provided with a list of qualified waiver providers. Percentage = number of waiver participants whose records documented provision of a list of waiver providers / total number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDS Individual Record Reviews

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.e.4. Number and Percentage of waiver participants whose records contained documentation that the service recipient or guardian/conservator, as applicable, was provided with a list of waiver services. Percentage = number of waiver participants whose records documented provision of a list of waiver services / total number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDS Individual Record Reviews

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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.
Per the CMS Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers released March 12, 2014, the following performance measures have been deleted: SPa.i.b1, b2, b3, b6, b7, b8. Those performance measures were deleted because the related subassurance, "The state monitors service plan development in accordance with its policies and procedures" was deleted per the CMS

Modifications. Per the same guidance, SP - a.i.e.1. was also deleted, "Waiver participants whose records contained the current Freedom of Choice form completed and signed by the participant or his/her guardian or conservator, which specifies that choice was offered between waiver services and institutional care."

Performance Measures a.i.c.1. and a.i.c.2., a.i.d.2. through a.i.d.4., 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 of the waiver year. The sample will be divided as evenly as possible to collect data during the following twelve (12) months. For each waiver participant included in the sample, Individual Record Reviews will be conducted by designated DIDD Regional Office staff. Staff will review waiver participant records, including claims data, to obtain the information needed to determine compliance with these performance measures.

b. 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.c.1. and a.i.c.2., and a.i.e.1. and a.i.e.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. Regional Office staff will monitor remediation actions until able to verify that the issue has been resolved satisfactorily. Remediation actions and timeframes are reported to TennCare monthly. TennCare notifies DIDD of any remediation determined unacceptable and requires DIDD to provide additional information and/or take additional remedial action until remediation can be determined appropriately completed. Support Coordination (ISC) and other provider agencies, as applicable, will be held accountable for taking appropriate personnel actions within 30 calendar days to address employee job performance, including, but not limited to training and retraining, verbal or written warning, suspension or termination. Other contracted providers will be held accountable, as appropriate, for resolution of issues involving ISP implementation. Remediation actions are expected to be completed within a targeted time frame of 30 calendar days.

Performance Measure a.i.a.4.: When individuals report issues with the ISP, the satisfaction survey (known as People Talking to People Survey) interviewer will notify the DIDD People Talking to People Director within three business days. The DIDD People Talking to People Director will take appropriate action, which could include filing a complaint if appropriate and in accordance with the waiver participant's wishes, or notifying the ISC of the waiver participant's need to consider plan amendment. The DIDD People Talking to People Director will monitor remedial actions and track remediation timeframes. Complaints filed will be resolved in accordance with DIDD complaint resolution processes. The DIDD goal is to resolve complaint issues within a 30 calendar day time frame. Designated DIDD staff will compile monthly information about complaints and complaint resolution, including complaint types and referral sources, into data files and the Quality Management Report, all of which will be submitted monthly to TennCare. Appeals filed will be processed in accordance with TennCare rules and TennCare approved DIDD policy.

Performance Measure a.i.d.2. through a.i.d.4.: TennCare and DIDD have determined that there are acceptable reasons when services may not be provided exactly in accordance with plan specifications. Such acceptable reasons (e.g., holidays, inclement weather, person supported choice, hospitalization) have been identified and shared with DIDD staff and waiver service providers through a memorandum. When service amount, frequency, or duration varies for acceptable reasons, compliance is indicated; however, data is tracked regarding the reasons services were not provided in the amount, frequency, and duration in approved plan. In situations where more services were billed than were actually provided or documented, DIDD reviewers will forward this information to designated DIDD administrative staff who will initiate recoupment procedures. If warranted, a provider may be referred to DIDD audit staff for a more extensive fiscal audit. The DIDD Deputy Commissioner will determine the need for more extensive provider level fiscal audits during monthly State Quality Management meetings.

Individual Remediation Data Aggregation: DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible DIDD staff and back-up staff are identified for each task. Designated DIDD Central Office staff compile the data collected and entered by regional and central office staff into DIDD databases to create data files that are posted for TennCare analysis and aggregation. In addition, DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

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

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

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 be provided to persons supported upon enrollment in the waiver.
2. DIDD 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 provided, or of any action to deny choice of available qualified providers.
3. Notice must be received by the persons supported prior to the date of the proposed termination, suspension, or reduction of waiver services unless one of the exceptions exists under 42 CFR 431.211-214.
4. A persons supported has the right to appeal the adverse action and to request a fair hearing.
5. Appeals must be submitted to the Bureau of TennCare within thirty (30) calendar days of receipt of notice of the adverse action. Receipt of any notice shall be presumed to be within five (5) calendar days of the mailing date.
6. Reasonable accommodations shall be made for persons with disabilities who require assistance with the appeal process.
7. Hearings shall be held pursuant to the provisions of the Tennessee Uniform Administrative Procedures Act and shall be held before an impartial hearing officer or administrative judge.
8. A written hearing decision shall be issued within ninety (90) calendar days from the date the appeal is received. If the hearing decision is not issued by the 90th day, the waiver service may under specified circumstances be provided until an order is issued.
9. Waiver services shall continue until an initial hearing decision if the persons supported appeals and requests continuation of waiver services within ten (10) calendar days or five (5) calendar days, as applicable under 42 CFR 431.213-214 and 431.231, of the receipt of the notice of action to suspend or reduce ongoing waiver services. If the denial decision is sustained by the hearing, recovery procedures may be instituted against the persons supported to recoup the cost of any waiver services furnished solely by reason of the continuation of services due to the appeal.
Notices of Fair Hearing that are required by 42 CFR §431.210, are maintained by the State entity (either TennCare or DIDD) that is responsible for issuing the notice.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   - (●) **No. This Appendix does not apply**
   - ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including:

(a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Bureau of TennCare and the Department of Intellectual and Developmental Disabilities (DIDD)

c. 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).

Resolution of complaints:
The majority of complaints that are unable to be resolved with the provider agency are filed directly with DIDD. 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 Coordinator will:
• 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 affecting the well-being of a person supported. All complaints will be maintained on a complaint log. Each HCBS waiver will have a separate log. Entries to the complaint log will include the following elements:
1. The name of the waiver participant(s)
2. Social security numbers of the participant(s) (if not available from the complainant, to be retrieved from the InterChange System)
3. The name and phone number of the individual reporting the complaint
4. The nature of the complaint(s) or problem(s)
5. The date the Department of Intellectual and Developmental Disabilities (DIDD) was notified of the complaint. If the complainant expressly requests that DIDD not be notified, the reason must be documented.
6. If the complaint is such that appeal rights are involved, documentation that the complainant was informed of such rights.
7. If appeal is requested by the complainant, documentation of the date of referral to the appropriate entity with request for a copy of the final directive.
8. Any actions taken to research, investigate, or resolve the complaint or problem, including dates of such action
9. The results of complaint investigations, including complaints that were validated and a general description of actions taken to resolve complaints (e.g., Corrective Action Plans)

Upon receiving a complaint, designated TennCare staff will determine from the complainant any provider or DIDD staff involved in resolving the issue prior to the complainant's contact with TennCare and the extent to which prior DIDD or provider actions have been successful in resolving the problem.
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 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 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 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.
TennCare and DIDD will work cooperatively to achieve complaint resolution. Once TennCare and appropriate DIDD staff have agreed on a course of action to resolve the problem, the complainant and any providers involved will be notified in writing of the proposed solution and expected date of resolution. 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. DIDD will be responsible for providing adequate follow-up documentation as requested by TennCare Waiver staff to document that the agreed upon actions were completed. All complaints filed with TennCare are expected to be resolved within 30 calendar days. DIDD will be required to provide written notification of complaint resolution to designated TennCare staff for and will be required to advise TennCare of any TennCare complaints for which resolution cannot be achieved within targeted timeframes. TennCare will continue to monitor remedial actions until it is determined that the problem is resolved and the complaint can be closed. Outstanding complaint cases will be discussed at the monthly TennCare/DIDD meetings.
The complainant will receive written notification from designated TennCare, including the data 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). 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.
Providers are asked to resolve all complaints in a timely manner, and within 30 calendar days of the date that the complaint was filed. 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 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.
Filing a complaint does not void an individual's right to request a fair hearing in accordance with 42 CFR Part 431, Subpart E, nor is it a prerequisite for a fair hearing.
DIDD collects information regarding waiver participant familiarity with the complaint process through the participant satisfaction survey. Information collected is compiled and reported to TennCare in monthly data files and the Quality Management Report. DIDD also reports monthly DIDD complaint data, including the number and type of complaints received, referral sources, remedial actions, and timeframes for achieving resolution. TennCare monitors DIDD complaint remedial actions on a monthly basis and advises DIDD of any that require further action.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events

occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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 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.
Critical events categorized as abuse, neglect, exploitation, suspicious injury, serious injury of unknown cause and unexpected/unexplained deaths are required to be reported to the DIDD Investigations hotline within four (4) hours of the discovery of the incident. The incident can be reported by telephone, email, and fax or in person. Within one (1) business day, the incident is reported by email or fax to DIDD Central Office and the ISC Agency/Support Coordinator using a Reportable Incident Form. For incidents that are not reported as abuse, neglect, exploitation, suspicious injury, serious injury of unknown cause or unexpected or unexplained death, a next business day reporting requirement is in place. Those incidents are reported via the Reportable Incident Form by email or fax. The hotline number and Reportable Incident Form are located on the DIDD Website.
If a provider reports an allegation of abuse, neglect or exploitation, they are required by State law to contact the appropriate authorities such as Adult Protective Services, Child Protective Services or law enforcement.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Participants and their families or legal representatives are provided the DIDD Family Resource Guide which includes information on how to report abuse, neglect, and exploitation to DIDD. The document is also posted on the DIDD website.
DIDD provides ongoing training for providers which include information on how to identify and who to contact when there is an allegation of abuse, neglect or exploitation. Providers use information from this training to educate persons supported and family members upon admission into their services. The Independent Support Coordinator is in regular contact with the person and their family and available to provide information should the need arise.
Additional information is also provided via posters and signs which are visibly posted and which outline the same practices taught in the original training. Finally, training is also provided on an as requested basis.

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 Unit receives allegations of abuse, neglect, exploitation, serious injuries of unknown cause and suspicious deaths. All such incidents are investigated by trained DIDD investigators who interview the participant, service provider, and all available witnesses. The DIDD investigators examine the incident scene and collect other available relevant circumstantial evidence (written statements, expert medical opinions as needed, etc.). Based on the 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 plan that addresses the issues and conclusions specified in

the DIDD Investigations report within 14 calendar days of the completion of the Investigation Report.
For all other "Reportable Incidents", DIDD requires the person witnessing or discovering the incident to ensure that a written incident report form is forwarded to the responsible waiver service provider and to DIDD. The service provider is required by DIDD to have incident management processes and personnel in place sufficient to review and respond to all "Reportable Incidents". The service provider is required to ensure that the incident and the initial response to the incident are documented on the incident report form, to review all provider incidents are reviewed immediately and discussed during biweekly meetings for the purpose of identifying any additional actions needed, and to organize all incident 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 prevention initiatives.
The relevant parties of an investigation are notified of the results of an investigation via the following:
1. DIDD will send a final DIDD Investigation Report, as well as, a DIDD
Summary of Investigation Report to the Executive Director and when applicable, to the Chair of the Board of Directors of the provider(s) responsible for the person(s) supported involved.
2. 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.
3. The provider will be expected to document reasonable attempts to notify alleged perpetrator(s) of the outcome of the investigation.
4. Within fifteen (15) business days of receipt of the DIDD Summary of Investigation Report, the summary shall be discussed with the person(s) supported involved to the extent possible (if a legal representative has been appointed, the legal representative shall be invited to participate), with such discussion conducted by a representative of the provider who supports the person. The provider will document the date and time of this discussion and the efforts to coordinate the meeting with the legal representative, as applicable.

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".

Investigation reports involving allegations of abuse, neglect, or exploitation are reviewed by the DIDD Director of Investigations and are available for review by the Bureau of TennCare.

All "Reportable Incidents" 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 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 related to that provider, and for comparison between service providers; and
e. Distribution of monthly reports to DIDD management and other staff.

All Incident 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 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 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.

Appendix G: Participant Safeguards

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

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

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

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

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).

The use of seclusion is prohibited.

All take-downs and prone restraints are prohibited.

Except for emergency situations that could not have been anticipated in which a restraint is needed to ensure the health and safety of the person or others, restraints 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 restraints; 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.

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 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.

Restraints, including chemical restraints, may be used only when necessary to protect the participant or others from harm and when less intrusive methods have been ineffective. Take downs and horizontal restraint are prohibited. The following mechanical restraints are prohibited: restraint vest, camisoles, body wrap, devices that are used to tie or secure a wrist or ankle to prevent movement, restraint chairs or chairs with devices that prevent movement, and removal of a person's mobility aids such as a wheelchair or walker.

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 mechanical restraint. Interventions that should be employed prior to the use of restraints must be documented in the person centered ISP. 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, or emergency medication (chemical restraint) is 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.

Time period limitations for the use of restraints will be determined on an individual basis. The modification will be assessed at the end of each individualized time period to determine if continued authorization is needed or if the use of restraints can be terminated and other methods can be utilized. Such determinations shall be made with appropriate agency staff including management and direct support staff as well as the behavior analyst and, as necessary, members of the Circle of Support as well as anyone else the individual or their representative wishes to include.

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 restraint 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. Such use of restraint must be justified as a necessary component of the least restrictive, most effective behavioral intervention. The use of personal or manual restraint 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. Provider staff who are responsible for carrying out the behavior support plan must be trained on the plan prior to implementation.

Emergency use of personal restraint or mechanical restraint constitutes a reportable incident and as such must comply with DIDD reporting procedures. The case manager must be notified of each use of emergency personal or mechanical restraint within 1 business day.

The use of a psychotropic medication requires a formal diagnosis and informed consent from the persons supported or their legal representative. In addition, the use of psychotropic medications requires review by a human rights committee. When emergency psychotropic medications are administered pursuant to physician's orders, a Reportable Incident Form must be completed and submitted.

Agencies must provide staff training in the area of proactive and reactive supports and restraints adequate to support individuals for whom they are responsible. Quality Assurance standards require that each staff member supporting a person with an approved personal safety system is provided training on its use. Agencies are required to show proof of this training during QA surveys.

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, is responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed.

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 any use of prohibited restrictive interventions as well as 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 restraints and other restrictive interventions:

a.i.22 Number and percentage of Behavior Support Plans (BSPs) that comply with State policies and procedures regarding the use of restrictive interventions.

This involves a 100% review of all Behavior Support Plans that include any restrictive intervention by the DIDD Director of Behavioral and Psychological Services.

a.i.23 Number and percentage of reported critical incidents NOT involving use of prohibited restrictive interventions.

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

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

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

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

◉ **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 and a Human Rights Committee and after informed written consent has been obtained from the person supported or the person's legal representative. The emphasis, however, is placed on developing effective behavior support plans that do not require the use of restrictive interventions. Person centered ISPs shall document positive interventions that are to be employed prior to the use of restrictive interventions. Staff must be trained on the use of positive interventions and document that positive interventions were employed prior to the use of restrictive interventions. If the use of restrictive interventions is required, such use is reevaluated with the goal of reducing or eliminating the continued use of the intervention as clinical progress permits.

The following types of restricted interventions are permitted:
1. Contingent effort;
2. Escape extinction;
3. Non-exclusion and *exclusion time-out;
4. Negative practice;
5. Contingent use of personal property or freedoms;

6. Delay of meals;
7. *Manual restraint;
8. Overcorrection, positive practice;
9. Response cost;
10. Satiation;
11. Substitution of food/meals;
12. *Mechanical restraint;
13. *Protective equipment;
14. Required (forced) relaxation; or
15. Sensory extinction.

*Restraints and protective equipment may be used only when necessary to protect the person supported or others from harm and when less intrusive methods have been ineffective. The application of restraint or protective equipment and exclusionary time-out to a specific location must be implemented carefully to ensure protection from harm and to protect the person's rights.

Behavior support plans including restricted interventions must be written by a DIDD approved Behavior Analyst. In special cases, the behavior analyst may request a variance from current policies given a person's unique needs. 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, 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.

The application review and approval process for behavior services providers is managed by the DIDD Director of Behavior and Psychological Services. Behavior analysts must have board certification as a behavior analyst (BCBA) to be approved, although providers with a graduate degree and a minimum of 12 graduate hours in behavior analysis are "grandfathered" pending a transition period to obtain such certification. Courses must focus upon behavior analysis, rather than more generic topics in the discipline for which the graduate degree was awarded. The courses should address the following issues in applied behavior analysis: ethical considerations in the practice of applied behavior analysis; definitions, characteristics, principles, processes and concepts related to applied behavior analysis; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; behavioral change procedures and systems support.

A DIDD approved behavior analyst must complete DIDD required training courses as specified in the Provider Manual and DIDD Staff Development plan. Once the behavior support plan has been developed by the behavior analyst, direct support staff are required to receive training on the implementation of the behavior support plan prior to working with the person supported.

All incidents involving the use of restraints are reported through the DIDD incident management system. Regional Office Behavior Analysis staff routinely (daily, weekly, monthly, annually) review incident reports to determine inappropriate or excessive use of restraint. When inappropriate or excessive use is identified, Regional Office Behavior Analysts investigate and follow up to ensure appropriate actions are taken to address any emerging problems. Examples of actions that might be taken include encouraging the person's circle of support to discuss retaining the services of a behavior analyst or reviewing an existing behavior support plan to determine what types of adjustments might be appropriate.

Agencies must provide staff training adequate to support individuals under their care. Quality Assurance standards require that each staff member supporting a person with an approved personal safety system is provided training on its use. Agencies are required to show proof of this training during QA surveys.

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, is responsible for monitoring and overseeing the 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.22 Number and percentage of Behavior Support Plans (BSPs) that comply with State policies and procedures regarding the use of restrictive interventions.

This involves a 100% review of all Behavior Support Plans that include any restrictive intervention by the DIDD Director of Behavioral and Psychological Services.

a.i.23 Number and percentage of reported critical incidents NOT involving use of prohibited restrictive interventions.

This involves a 100% review of all incidents reported in the DIDD Incident 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)

c. 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.)*

◉ **The State does not permit or prohibits the use of seclusion**

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, is responsible for detecting the unathorized use of seclusion.

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 use of seclusion as well as the inappropriate use of other 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.22 Number and percentage of Behavior Support Plans (BSPs) that comply with State policies and procedures regarding the use of restrictive interventions.

This involves a 100% review of all Behavior Support Plans that include any restrictive intervention by the DIDD Director of Behavioral and Psychological Services.

a.i.23 Number and percentage of reported critical incidents NOT involving use of prohibited restrictive interventions.

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

Any instances of the use of seclusion (or other inappropriate use of restrictive interventions) will be promptly remediated.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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. **Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **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.

All waiver service providers employing staff who administer medications to persons supported have ongoing responsibility for monitoring to ensure that medications are correctly administered and that medication administration is appropriately documented in accordance with DIDD requirements. Providers must have written policies and procedures for medication administration and implementation of such policies is evaluated during annual DIDD Provider Performance Surveys. On an ongoing basis, providers are required to report medication variances that have caused, or are likely to cause harm to a person supported. DIDD Regional Office staff receive and review reportable incident forms for completeness and determination of the nature of the incident. DIDD monitors for medication variance trends utilizing data from the Incident and Investigations database.
During DIDD Provider Performance Surveys, DIDD Regional Quality Assurance surveyors review a sample of person's Medication Administration Records to identify potentially harmful practices and to ensure compliance with medication administration documentation requirements. Medication variance reports are also reviewed. Provider medication management policies and practices are reviewed to ensure that:
a. The Medication Administration Record correctly lists all medications taken by the person supported;
b. The Medication Administration Record is updated, signed, and maintained in compliance with DIDD medication administration documentation requirements;
c. All medications are administered in accordance with prescriber's orders;
d. Medications are administered by medication administration certified staff;
e. Medications are kept separated for each person supported and are stored safely, securely, and under appropriate environmental conditions.
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 Behavior Support and/or Human Rights Committees.
Personnel records are reviewed to ensure that licensed staff who administer medications are appropriately licensed and that unlicensed staff who are permitted by state law to administer medications have documentation of completion of current medication administration certification.

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 is responsible for oversight of medication management. During annual Provider Performance Surveys, DIDD reviews the person supported Medication Administration Record (MAR) to identify potentially harmful practices and to ensure compliance with documentation requirements. Medication variance reports are reviewed. Personal Records are reviewed to ensure that licensed staff who administer medications are appropriately licensed and that unlicensed staff who are permitted by state law to administer medications have documentation of current medication administration certification. When the DIDD quality assurance surveyors identify potentially harmful medication administration/management practices, the surveyors notify the provider during the survey and then review such issues during the exit conference at the end of the survey. In addition, the provider is notified in writing of any problems identified during the survey, and the provider is required to take appropriate action to resolve such problems in a timely manner. When deficiencies are identified, the DIDD Regional Director is notified and is responsible for ensuring that DIDD Regional Office staff follow up to verify timely and appropriate resolution.
Providers are required to complete a reportable incident form for medication variances if the variance is category E to I on the Medication Variance Form, and a copy of the DIDD Medication Variance Report is submitted with the RIF. 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. Provider agencies are responsible for identifying medication variance trends. Agencies with systemic performance issues identified regarding medication administration during the annual quality assurance survey are discussed during the monthly State Quality Management Committee Meeting.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. **Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Nurse Practice Act in Tennessee generally prohibits administration of medication by unlicensed individuals. There is, however, a statutory exemption for providers who administer medications to individuals receiving services through the Department of Intellectual and Developmental Disabilities (DIDD). This exemption permits certain unlicensed direct support staff to administer medications after successfully completing medication administration certification developed by DIDD. After completing the training program, the individual may administer medications within specified parameters and in accordance with the

prescriber's order; however, the individual is not permitted to administer medications when such administration requires judgment, evaluation, or assessment before the medication is administered. The individual must make a written record of any medication that is administered, including the time and amount taken.

iii. Medication Error Reporting. *Select one of the following:*

(●) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

The provider agency is required to complete the approved DIDD incident form used to report all medication variances. This form includes information that specifies the name of the physician notified and the date and time of notification. Medication variances are reported to DIDD. DIDD reviews medication variance reports monthly to determine trends that must be addressed with contracted providers or systemically.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record a medication variance whenever a medication was given in a way that was not consistent with the prescriber's orders, including the following:

1. Medication was given to the wrong person;
2. Medication was given at the wrong time;
3. Wrong dose of medication was given;
4. Wrong form of medication was given (e.g., tablet instead of liquid form);
5. Wrong medication was given;
6. Medication was given by the wrong route of administration;
7. Failure to give the medication; or
8. Medication was not prepared according to the physician's orders (e.g., was not crushed).

(c) Specify the types of medication errors that providers must *report* to the State:

A medication variance must be reported if it:
1. Requires intervention and caused, or is likely to cause, the person temporary harm;
2. Caused, or is likely to cause, temporary harm requiring hospitalization;
3. Caused, or is likely to cause, permanent harm to the person;
4. Resulted in a near death event (e.g., anaphylaxis, cardiac arrest); or
5. Resulted in or contributed to the person's death.

( ) **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The state agency responsible for monitoring the performance of waiver providers in the administration of medications to persons supported Department of Intellectual and Developmental Disabilities (DIDD). Provider Performance Surveys are conducted annually by the DIDD Regional Quality Assurance Units to assess the performance of waiver providers in the administration of medications. All waiver service providers who administer medications to persons supported are subject to Provider Performance Surveys and

are monitored annually unless they meet established criteria for reduced frequency of monitoring. During Provider Performance Surveys, DIDD Regional Office nurses serve as consultants to non-nurse surveyors.
The following Quality Assurance Indicators are evaluated during Provider Performance Surveys:
1. Medication variances are reported and addressed in a timely manner.
Compliance with requirements to detect, respond to, and report medication variances in accordance with DIDD policy and procedures is assessed. Surveyors determine if the agency has developed and implemented effective procedures for oversight of medication administration and reporting medication variances.
2. The provider analyzes trends in medication variances and implements prevention strategies.
Monitoring is conducted to assess compliance with the requirement that the agency has policies and procedures in place for tracking and trending medication variances that include implementation of prevention strategies. Reviews are conducted to assess whether the agency has a self-assessment process to review medication administration variance; whether the agency reviews recommendations resulting from monitoring; and whether the agency has implemented corrective action in response to recommendations.
3. The person's record adequately reflects all the medications taken by the person.
Surveyors assess whether current prescriber's orders are present for each medication received by the person supported.
4. Needed medications are provided and administered in accordance with prescriber's orders.
Surveyors assess documentation of medication administration or refusal, identification of medication variances with required action being taken, and monitoring of medication self-administration.
5. Only appropriately certified staff administer medication.
Surveyors assess whether licensed staff who administer medications have a current license, unlicensed staff who administer medications have received appropriate training, whether there has been appropriate delegation of medication administration by a registered nurse, and whether the provider conducts ongoing monitoring of staff administering medications.
6. Medication administration records are appropriately maintained.
Surveyors assess compliance with the requirement that agencies must develop and implement procedures for oversight and completion of the Medication Administration Records. Surveyors also assess compliance with the requirement that providers must maintain information on medication side-effects and that the MAR matches prescription labels and prescriber's orders.
7. Storage of medication ensures appropriate access, security, separation, and environmental conditions.
Surveyors assess the provider's compliance with the requirement that provider medication administration policy address procedures for and monitoring of medication storage and disposal.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Participant Satisfaction Survey

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.8. Number and percentage of DIDD investigations by critical incident type completed within 30 calendar days. Percentage = number of investigations by critical incident type completed within 30 days / total number of investigations completed during the reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Incident and Investigation Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.11. Number and percentage of waiver participants for whom all critical incidents were reported as noted in the primary record and/or support coordination record. Percentage = number of unduplicated waiver participants for whom all critical incidents noted in the primary record and/or support coordination record were reported/total number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Individual Record Reviews

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Participant Satisfaction Survey

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative**

		Sample Confidence Interval = +/- 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.9. Number and percentage of completed DIDD Investigations for which abuse, neglect, and/or exploitation was substantiated, by type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Incident and Investigation Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Participant Satisfaction Survey

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

☐ **Continuously and Ongoing**	
☐ **Other** Specify:	

Performance Measure:
a.i.1. Number and percentage of waiver participants who received medical exams in accordance with TennCare Rules. Percentage = number of waiver participants who had timely medical examinations / total number of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Individual Record Reviews

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.13. Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause. Percentage = number of deaths of unexplained or suspicious cause / total number of deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Incident and Investigation Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.10. # and % of substantiated investigations, total and by type,for which appropriate corrective actions approved by DIDD were verified within 45 days of issuance of the investigation report.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Incident and Investigation Database

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.17. Number and percentage of complaints appropriately resolved within 30 days of receipt. Percentage = number of complaints appropriately resolved within 30 days / total number of complaints received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Complaint Logs

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**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.19 Number and percentage of Plans of Correction related to substantiated investigations, required to be submitted by DIDD providers, which are accepted by DIDD after review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Regional Office review

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.20 Number and percentage of DIDD providers surveyed by DIDD who demonstrate regular review of their critical incidents, as required by DIDD.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDD Quality Assurance Surveys

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.21 Number and percentage of DIDD providers surveyed who demonstrate they are implementing preventive/corrective strategies when applicable.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
DIDD Quality Assurance Surveys

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.22 Number and percentage of behavior support plans (BSPs) developed for waiver participants that comply with State policies and procedures regarding the use of restrictive interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review by DIDD Director of Behavioral and Psychological Services

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.23 Number and percentage of reported critical incidents NOT involving the use of prohibited restrictive interventions.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Incidents and Investigations

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each*	**Frequency of data aggregation and analysis***(check each that applies):*

that applies):	
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.24 Number and percentage of DIDD providers who develop and maintain policies, and implement practices, in accordance with the DIDD Provider Manual and policies that achieve outcomes related to health care management and oversight.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Assurance (QA) Surveys

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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.
Note: a.i.19 - a.i.24 are new performance measures in response to the CMS Modifications released in March 2014. The state is proposing to delete a.i.14.: Deaths of unexplained or suspicious cause for which a substantiated investigation determined the death to be a direct result of abuse, neglect, or exploitation. This

information is captured in HWa.i.9 and HWa.i.13. The way HWa.i.14 was written did not work in the monthly reporting period required of performance measures, as the conclusion of the cause of death and the outcome of a related investigation are never available within the same month as the death. Tennessee tracks that specific information, the deaths of unexplained or suspicious causes for which a substantiated investigations is determined to be the cause of a death, via the DIDD Death Review Process.

Performance Measures a.i.1. and a.i.11.: A representative sample of waiver participants will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible to collect data during the following twelve (12) months. For each waiver participant included in the sample, Waiver Individual Record Reviews will be conducted by designated DIDD Regional Office staff.
Performance Measures a.i.2, a.i.3 and a.i.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 DIDD policies and procedures for identifying and reporting complaints and incidences of abuse, neglect, and exploitation.

Performance Measures a.i.8, a.i.9, a.i.13. and a.i.23 Data describing reportable critical incidents and investigations is entered on an ongoing basis into the DIDD Incident and Investigation Database. Monthly reports are generated that include data describing critical incidents reported and investigations initiated/completed during the month. This data will be compiled by designated DIDD staff and analyzed and trended monthly, year-to-date, and annually by DIDD Regional and State Quality Management Committees. DIDD also performs death reviews. Waiver service providers are required to report any death that is or may be a Suspicious, Unexpected, or Unexplained Death within four hours of discovery to designated DIDD Regional Office staff who record the circumstances of the death. Within one business day of the date of the death, a Notice of Death form must be completed by the waiver service provider and submitted to the DIDD Regional Director. Upon receipt of a Notice of Death form, the DIDD Regional Director or designee schedules a Preliminary Death Review Committee meeting. Within five business days of receipt of the Notice of Death, the Preliminary Death Review Committee shall perform a preliminary death review to determine if the death was Suspicious, Unexpected, or Unexplained. Any death determined to be Suspicious, Unexpected, or Unexplained shall trigger a DIDD Investigation, the preparation of a Clinical Death Summary, and a DIDD Death Review. The purpose of a DIDD Death Review is to conduct a comprehensive analysis of the relevant facts and circumstances, including the medical care provided, to identify practices or conditions which may have contributed to the death and to make recommendations, where necessary, to prevent similar occurrences.

Performance Measures a.i.17: Complaints filed with TennCare are referred to DIDD for resolution and are tracked on the DIDD Complaint Log. The DIDD Customer Focused Government Unit is responsible for reporting complaint resolution strategies and timeframes required for complaint resolution to the TennCare Complaint Coordinator. Complaints are expected to be resolved within 30 calendar days of referral.

Performance Measures a.i.10 and a.i.19: DIDD Regional Office Investigations Follow-up staff are responsible for verifying that appropriate corrective actions were completed within 45 days of issuance of the investigation findings.

Performance Measures a.i.22 and a.i.24 are reviewed during DIDD Quality Assurance (QA) Surveys. QA Surveys are conducted on 100% of providers annually. A sample of providers is generated each month.

b. 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.1.: When waiver participants are identified who have not received timely medical examinations, DIDD Regional Office staff will notify the Support Coordinator and any other providers, as applicable, to appropriately facilitate completion of a medical examination. Completion of the medical examination is expected within 30 days. Support Coordination and other provider agencies, as applicable, will be held accountable for taking appropriate personnel actions within 30 days to address individual DIDD case manager job performance, including, but not limited to training and retraining, verbal or written warning, suspension or termination. Support Coordination and other provider agencies, as applicable, will be required to report resolution dates to DIDD monthly.

Performance Measures a.i.2., a.i.3 and a.i.4.: When individuals do not know how to report complaints, 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 reporting instruction within 60 days to verify that the person who received information knows how to report complaints 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, 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. Negative responses to participant survey questions will be reported to the DIDD People Talking to People Director within three working days. The DIDD People Talking to People Director will ensure that a complaint is filed, if appropriate and in accordance with the waiver participant's wishes. The DIDD People Talking to People Director will track resolution of issues identified, as well as timeframes to achieve resolution. Complaints filed will be resolved in accordance with DIDD complaint resolution processes. DIDD' goal is to resolve complaint issues within a 30 day time frame. Monthly information about complaints and complaint resolution, including types of complaint and referral sources, will be reported to DIDD Central Office staff responsible for data aggregation.

Performance Measures a.i.8., a.i.9, a.i.13 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. DIDD Regional Office Investigations Follow-up staff are responsible for verifying that appropriate corrective actions were completed within 45 days of issuance of the investigation findings. Investigations results and follow-up actions will be reported monthly to DIDD Central Office staff responsible for data aggregation.

DIDD Death Reviews are conducted within 45 business days of the individual's death; however, the time period may be extended by the DIDD Deputy Commissioner for good cause. The Regional Death Review Committee conducts a Death Review of any death determined to be Suspicious, Unexpected, or Unexplained and prepares detailed minutes including conclusions and recommendations for corrective actions. DIDD Regional Office staff ensure that the appropriate providers receive copies of the Committee's conclusions and recommendations. DIDD Regional Office Staff verify whether provider corrective actions are appropriately implemented within 45 days of the date the written conclusions/recommendations are.

Performance Measure a.i.11.: When unreported critical incidents are identified, the reviewer will immediately contact the appropriate provider to request that a late report be filed within two working days and will verify that the complaint was actually filed either by observing the completed report and evidence of submission or by verifying receipt of the report with appropriate Regional Office staff. Failure to file timely critical incident reports may result in provider sanctions as specified in the Provider Agreement. The number of unreported critical incidents discovered will be reported by reviewers via entry into a database that is used by DIDD Central Office staff for data aggregation. Both a DIDD monthly Quality Management Reports and data files containing discovery and remediation data are submitted to TennCare.

Performance Measure a.i.20, a.i.21: When providers cannot demonstrate, during their annual Quality Assurance survey, that they regularly review their critical incidents, DIDD issues a 'finding' and requires remediation within 30 days. Likewise, when providers cannot demonstrate that they are implementing corrective actions outlined in their Plans of Correction related to substantiated incidents, DIDD will report those instances.

Performance Measure a.i.22: The DIDD Director of Behavioral Services will review behavior support plans (BSPs) to ensure that they comply with state policies and procedures related to restrictive interventions.

Performance Measure a.i.23: The number of critical incidents that involve the use of prohibited interventions will be tracked and reported.

Performance Measure a.i.24: When providers are not able to provide evidence of policies and practices that achieve outcomes related to health care management and oversight, DIDD will issue a finding.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State’s goal is to maintain a quality improvement system that identifies problems, assesses the scope of the problem and ensures that system redesign strategies proactively address issues statewide. This section addresses the process of determining, developing, and implementing statewide remediation strategies.

Remediation strategies implemented to address issues affecting the quality of services offered in the waiver program are vital. It is equally important to evaluate the scope of the problem, so that broader improvements can address the potential for issues to affect other persons supported. One of the State’s remediation strategies includes DIDD Regional and State Quality Management Committee monitoring systems.

Regional Quality Management Committees (RQMC)

Each region has an RQMC meeting at least monthly to review provider performance. The RQMC reviews Quality Assurance surveys, Complaint data, Incident and Investigation data or any other issues warranting attention.

Gathered information is analyzed to:

1. determine the scope of each discovery or remediation problem identified (both isolated and systemic);

2. identify whether additional data is needed for cause of the issue;
3. develop recommendations for remediation / improvement strategies ; and
4. evaluate the effectiveness of improvement strategies previously implemented.

The DIDD RQMC is responsible for monitoring provider level remediation and regional improvement strategies through analysis of performance measure data collected. Provider specific issues / data and Regional analysis will be presented to the SQMC throughout the course of the waiver year through a quality management report.

Statewide Quality Management Committee (SQMC)

The SQMC is comprised of management level staff from the Central Office in addition to Regional Office representation. The SQMC analyzes regional data submitted to identify trends, initiate follow up actions, ensure statewide consistency and maintain oversight of RQMC activities.

During the monthly meetings, a prepared Statewide Quality Management Report containing submitted data from all RQMCs is reviewed. The report contains provider information and data for the previous month along with cumulative year-to-date compliance data.

The SQMC reviews:

1. the analysis performed by RQMC's on monthly, cumulative year-to-date, or annual findings;
2. the appropriateness and adequacy of any improvement strategies recommended;
3. the aggregated data for indications of statewide systemic issues;

The SQMC may also determine improvement strategies for systemic level issues and identify the best process for developing those strategies. Appropriate DIDD staff may be assigned as lead for specific responsibilities.

Remediation data received from the RQMCs on provider performance is collated and produced into a monthly DIDD State Quality Management Report. Designated DIDD Central Office Compliance Unit staff develop the report for CMS assurance and sub-assurance performance measure results. This information is reviewed by DIDD and TennCare.

Statewide Continuous Quality Improvement Committee (SCQI)
The SCQI is comprised of management level staff from DIDD Central Office and senior level staff from TennCare. The purpose of this committee is to ensure TennCare's involvement in the ongoing monitoring of overall waiver performance. This committee meets monthly and is focused on statewide systemic trends and issues. Isolated issues are presented as they relate to the minimum compliance threshold because TennCare and DIDD require a 100% remediation standard. The committee reviews, at a minimum:
1. Systemic remediations,
2. Quality Assurance Summary (performance percentages of all providers by type),
3. Status of providers receiving Mandatory Technical Assistance, and
4. Focused performance measure review.
The goals of the SCQI committee are:
1. Identifying systemic issues through the study of the data,
2. Intervene with appropriate, effective quality improvement strategies,
3. Monitor implementation of quality improvement strategies to ensure prevention of reoccurrence of performance issues, and
4. Brainstorm innovative ideas for continuously improving programs and services.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Performance measures with a compliance percentage below 86% consistently in a quarter (i.e. once every 3 months) are assessed for systemic impact with a Quality Improvement Plan developed and implemented if indicated.
1. Monthly, year-to-date, and annual performance measure data will be monitored during the course of the subsequent months to determine if system redesign strategies employed to address regional and state level performance problems were effective in increasing compliance percentages.
2. The DIDD Program Operations unit is responsible for monitoring and evaluating the effectiveness of provider improvement strategies with input and assistance provided by the SQMC, and oversight from TennCare.
3. Consideration will be given as to whether aggregate data indicates a system-wide issue. Annual recommendations on long term improvement strategies will be made by the DIDD Program Operations unit staff to the SQMC. The appropriate DIDD senior management staff will develop a work plan for those measures to be addressed in the coming year. Appropriate DIDD leadership staff will be responsible for the oversight of implementation of the work plan. Results will be reported to TennCare in monthly SCQI meetings.
4. DIDD posts monthly discovery and remediation data files allowing TennCare to generate Compliance Summary Reports containing information on Individual Record Reviews completed, percentage of compliance for each performance measure, number of findings remediated, and timeframes required for remediation.
The TennCare Director of Quality and Administration- Intellectual Disabilities Services, with assistance and input from TennCare Long Term Services and Supports division staff, will have responsibility for monitoring and evaluating the effectiveness of improvement strategies specifically applicable to identified systemic issues and TennCare processes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

At least annually, the SQMC will review the information needed to assess waiver quality or whether aspects of the quality improvement system require revision and submit recommendations to TennCare. The SQMC will also consider if existing performance measures are appropriate, if revision or deletion of existing measures should be undertaken, or if new performance measures should be added. This information is provided to TennCare as necessary for consideration.

Monthly State Continuous Quality Improvement Committee (SCQI) meetings are held as an opportunity for a collaborative review between DIDD and TennCare concerning issues related to the overall quality of the HCBS waivers. Included in the agenda of these meetings are the performance data, remediation and validation results for the previous month, results of DIDD quality assurance surveys, and a summary of the actions taken at the previous SQMC. As appropriate, additional areas such as DIDD Protection from Harm, Legal Affairs and Provider Development are discussed.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the

financial audit program. 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).

The Department of Intellectual and Developmental Disabilities (DIDD) requires 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 Independent Audit is an industry standard audit performed by a CPA/accounting firm to verify that the provider's business practices adhere to Generally Accepted Accounting Principles (GAAP). To ensure that auditors are truly independent, a preliminary step to all such audits includes written verification that no conflicts of interest exist between the auditor and the agency or firm being audited.
All provider types are included in the audit requirement. All providers, whether independent or part of a larger organization, are reviewed to ensure compliance with the Independent Audit requirement if they meet the $750,000 threshold.
DIDD maintains a listing of all providers with "total annual funding" listed (i.e., aggregate state and federal funds). The Fiscal Accountability Review (FAR) unit of the Office of Quality Management conducts annual on-site reviews of all applicable providers, per DIDD policy, to determine compliance with the Independent Audit requirement. If reviewers find that an Independent Audit has not been completed within the past 12 months, a "finding" is issued and the provider is required to submit a written corrective action plan and, as soon as completed, a copy of the Independent Audit.
B. Financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits:
Utilization Review Process - The Bureau of TennCare conducts utilization reviews of the HCBS waivers for persons with intellectual disabilities to determine compliance with federal and state regulations and waiver requirements. Post-payment claim reviews to ensure that services are appropriately documented and appropriately billed are conducted as part of the utilization review process.
Utilization reviews are conducted according to a predetermined audit schedule for the year. Reviews are conducted in each region of the state, and cover different waiver services each month. The person served` sample is identified by entering the following data into the TennCare Interchange System: 1.) waiver provider number; 2.) dates of service; 3.) procedure code for the review; and 4.) paid status. The process includes a review of the approved service plan with the amount, frequency and duration, review of the billing documents and supporting documentation, and a comparison of all documents to adjudicated claims. Identified inconsistencies are documented and researched. Unsupported and/or inappropriate payments result in recoupment.
Fiscal Accountability Review (FAR) – The DIDD Office of Quality Management, Fiscal Accountability Review (FAR) Unit monitors contracts and conducts onsite reviews. A review of the claims billed is compared to supporting documentation and all discrepancies are noted in a report that is submitted to the contract provider for comment. Recoupment for unsupported charges is made after review of the agency's comments. The initial report and final resolution is then submitted to TennCare for additional follow up where appropriate.
State of Tennessee, Department of Audit, Audit Manual, Section A-2 - Audits cover at least one fiscal year, 12 months, unless otherwise approved by the Comptroller. The Bureau of TennCare (State Medicaid Agency) is subject to an annual audit as required by the Single Audit Act. The audit includes a random sample of each program and includes the 1915c HCBS waiver programs. Requests for documentation to support paid claims are made directly to selected providers by the Department of Audit and all information is submitted by providers to this Department. At the completion of the audit process, a comprehensive report is submitted to TennCare staff for review and follow-up to insure that findings are not repeated in subsequent years.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
    i. **Sub-Assurances:**
        a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with***

the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.3. # and % of paid claims for services delivered to persons enrolled in the waiver in accordance with the approved ISP and with documentation to support the amount, frequency, and duration of services billed. % = # of paid claims for services delivered to persons enrolled in the waiver in accordance with the ISP and with documentation to support paid claims / total number of claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DIDS Fiscal Accountability Review (FAR) Audit Data

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: (See a.ii)
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.1. Number and percentage of claims denied or suspended for incorrect billing codes and service rates. Percentage = number of claims denied or suspended / total number of claims submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TennCare Remittance Advice Reports

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.4 Number and percentage of rates approved that are consistent with the approved rate methodology throughout the five year waiver cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
State reports the total # of claims received with billed amounts more than the

approved waiver max fee schedule, which are automatically reduced to be paid according to the approved rate methodology.

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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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.
Note: Performance measure a.i.4 is new, in response to the CMS Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, issued in March 2014.

Performance Measure a.i.3.("Less than 100% review: Other) DIDD FAR reviewers survey 100% of providers with paid claims in excess of $500,000 for the previous fiscal year. A sample of 10% of waiver participant records (not to exceed 30 records) is selected for the review of providers with paid claims exceeding $500,000. For providers with paid claims exceeding $5 million, the sample size increases to 20% (not to exceed 40 records). Reviewers select their samples which must include a billing period of at least three months of the billing year. TennCare Utilization Review processes focus on providers with paid claims less than $300,000 per year.

b. 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 Measure a.i.1.: The TennCare 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. 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 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 requesting corrective action, which may include procedural changes, staff training, or staff disciplinary actions. DIDD 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.3.: Findings from DIDD FAR reviews are included in an audit report that is sent to the audited provider and copied to the appropriate DIDD, TennCare and Comptroller staff. Repeat findings are identified in the report. Payments made for claims with inadequate or missing information are recouped, unless the provider responds with additional information to justify claims billed. Providers will be required to submit a management response to DIDD FAR reports within 15 business days. Responses may include additional information to justify billing, agreement with findings and identification of management strategies to improve documentation and billing processes, or a combination of both. For responses not received within 15 business days, the DIDD FAR Director will send a notice advising that the recoupment is due within 30 days and will provide instructions for accomplishing the recoupment. The DIDD FAR Director will track recoupments in a database. At the end of each review period (calendar year), a final reckoning process will be initiated. If recouped amounts have not been collected from the provider, the amount will be withheld from provider payments so that all recoupments for the review cycle are collected no later than the end of the first quarter of the subsequent calendar year (March 31). DIDD FAR reviewers collect information identifying the waiver program in which the waiver participant whose records are being reviewed is enrolled. Consequently, review data is available by waiver program. DIDD reports monthly concerning the number of paid claims and findings if applicable. The FAR Director completes an annual summary regarding collection of recoupments from providers resulting from DIDD FAR findings and submits this to TennCare.

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.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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).

Proposed service rates are determined by the Department of Intellectual and Developmental Disabilities (DIDD) and are approved by TennCare, the State Medicaid Agency. The State Medicaid Agency, TennCare, has oversight of the rate determination process. TennCare reviews and approves all rates and keys approved rates into the MMIS for purposes of processing claims for waiver services.

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. 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 state programs are considered. Providers are reimbursed up to the maximum allowable rate established for a service.

Stakeholders have the opportunity to provide input into the development and sufficiency of rates through 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. Information about payment rates is made public and is available on the DIDD web site, i.e., TennCare Maximum Reimbursement Rate Schedule.

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 ISP.
The DIDD system converts the provider claims that successfully process through all of its edits to the appropriate claim format and submits the claims electronically to TennCare for processing through the MMIS. The MMIS processes the claims, and returns the remittance advices electronically to DIDD and a hard copy to each provider. TennCare issues reimbursement payments to the providers. Providers retain 100% of the payment calculated in the MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- [ ] **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

- [ ] **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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 approves services in the ISP. 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. When the claims process 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. Claims are also processed against a number of other edits or audits specific to service limits within the MMIS. Post-payment reviews are conducted by the DIDD Internal Audit Unit and by TennCare to ensure services were provided.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver

services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) The Department of Intellectual and Developmental Disabilities (hereinafter “Department” or “DIDD”) is a public government organization which delivers health care services to people with intellectual and developmental disabilities who are enrolled in the State’s Medicaid waiver. Department employees deliver health care services at the DIDD Regional Resources Centers located in West, Middle, and East Tennessee. The health care services delivered by DIDD employees include behavior services, dental services, nutrition services, occupational therapy, physical therapy, specialized medical equipment, supplies, and assistive technology, and speech language and hearing services. The Department contracts with other qualified providers to furnish other waiver services. All Department employees delivering said health care services, as well as other qualified providers, are required to satisfy waiver requirements regarding qualifications and service standards.
(b) The Department does not require waiver providers to affiliate with the Regional Resource Centers. Waiver providers who elect not to affiliate with the Regional Resource Centers are able to enter into a three-way agreement with the Department and the single State Medicaid Agency (TennCare) through the usual and customary process for direct provider enrollment. A waiver provider’s decision on whether or not to agree to contract with the Regional Resource Centers does not have any bearing on the provider’s enrollment as a waiver provider.
(c) Waiver participants are not required to secure services through the Regional Resource Centers. When an individual is determined to be likely to require the level of care provided by an ICF/IID, DIDD informs the individual or the individual’s legal representative of any feasible alternatives available under the waiver program, including a description of the waiver services and names and addresses of all available qualified providers, and offers the choice of either institutional or waiver services.
In addition, individuals are given a Freedom of Choice form which contains a simple explanation of the

waiver and waiver services; a statement that participation in the Waiver is voluntary; and notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment. The Freedom of Choice form is explained and the signature of the person to receive waiver services or the legal representative will be obtained on the Freedom of Choice form, which is completed prior to admission into the waiver program.
(d) Any staff person who has direct contact with or direct responsibility for a waiver participant must pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities 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.
A statewide criminal background check is performed by the Tennessee Bureau of Investigation or a Tennessee-licensed private investigation company. If the staff person has resided in Tennessee for one year or less, a nationwide criminal background check is required in accordance with DIDD requirements. The Bureau of TennCare shall conduct Qualified Provider Reviews of DIDD personnel files to ensure that there is documentation that the mandatory background and registry checks have been conducted on potential staff that will have direct contact with or direct responsibility for waiver participants.
(e) TennCare reviews and approves the final language contained in the three-way provider agreement template which specifies provider requirements and responsibilities as well as DIDD and TennCare responsibilities in administration/operation of the waiver program. TennCare reviews individual waiver provider and administrative contracts prior to execution and is a signatory on all such contracts. This process assures that OHCDS contracts meet applicable requirements.
(f) Financial accountability is assured through the audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services.
Utilization Review Process - The Bureau of TennCare conducts utilization reviews of the HCBS waivers for persons with intellectual disabilities to determine compliance with federal and state regulations and waiver requirements. Post-payment claim reviews to ensure that services are appropriately documented and appropriately billed are conducted as part of the utilization review process. Utilization reviews are conducted according to a predetermined audit schedule for the year. Reviews are conducted in each region of the state, and cover different waiver services each month. The person sample is identified by entering the following data into the TennCare Interchange System: 1.) waiver provider number; 2.) dates of service; 3.) procedure code for the review; and 4.) paid status. The process includes a review of the approved service plan with the amount, frequency and duration, review of the billing documents and supporting documentation, and a comparison of all documents to adjudicated claims. Identified inconsistencies are documented and researched. Unsupported and/or inappropriate payments result in recoupment.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§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 §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

There are 5 residential services offered through this waiver: Intensive Behavior Residential Services, Supported Living, Residential Habilitation, Medical Residential Services, and Family Model Residential Support. In addition, there are two services that individuals may use on a temporary basis - Behavioral Respite Services and Respite. As per 42 CFR 441.310(a)(2), FFP may be claimed for respite services that are provided in a facility approved by the State. When Respite services are provided in a private residence, room and board costs are excluded from the provider's reimbursement rate.

With the exception of a live-in companion for which the companion's share of room and board costs is allowed, the residential rate structures include only staffing and program costs and exclude all room and board costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ( ) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

- (●) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Supported Living is the only service in the waiver in which housing and food expenses of an unrelated live-in caregiver will be reimbursed provided that the recipient does not live in the caregiver's home or in a residence that is owned or leased by the provider. The housing and food expenses of the unrelated caregiver will be based on the proportionate share of the household's housing and food expenses.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	70980.75	4220.05	75200.80	155718.05	3859.58	159577.63	84376.83

2	70980.75	4346.65	75327.40	160389.59	3975.36	164364.95	89037.55
3	70980.75	4477.05	75457.80	165201.28	4094.63	169295.91	93838.11
4	70980.75	4611.36	75592.11	170157.32	4217.46	174374.78	98782.67
5	70980.75	4749.70	75730.45	175262.04	4343.99	179606.03	103875.58

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	5072	5072
Year 2	5072	5072
Year 3	5072	5072
Year 4	5072	5072
Year 5	5072	5072

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was derived from the most recently filed CMS 372 report for the Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled (control number 0128) for the period January 1, 2012, through December 31, 2012.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Twelve month actual participant expenditure data from DIDD formed the basis of estimates of participant utilization and average number of units per user by type of service.

The State will serve the lesser of the number of unduplicated users specified for each year of the waiver or the number it is able to serve with funds appropriated for the DIDD by the legislature each year.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of

these estimates is as follows:

The basis for Factor D' was derived from the average per capita acute medical costs for this waiver population reported on the most recently filed CMS Form 372 report for this waiver(control number 0128) for the year which ended 12/31/12. This data was trended forward for each year of the waiver, anticipating a 3% rate of inflation.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The basis for Factor G was derived from the annualized average per diem cost of private ICF/IID services as determined by the Tennessee Office of the Comptroller. This data was trended forward for each year of the waiver, anticipating a 3% rate of inflation.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The basis for Factor G' was derived from the average per capita acute care expenditures for the institutionalized population as reported on the most recently filed CMS Form 372 report for this waiver (control number 0128) for the year which ended 12/31/12. This data was trended forward for each year of the waiver, anticipating a 3% rate of inflation.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Residential Habilitation
Respite
Support Coordination
Nursing Services
Nutrition Services
Occupational Therapy
Physical Therapy
Specialized Medical Equipment and Supplies and Assistive Technology
Speech, Language, and Hearing Services
Adult Dental Services
Behavior Services
Behavioral Respite Services
Employment and Day Services
Environmental Accessibility Modifications
Family Model Residential Support
Individual Transportation Services
Intensive Behavioral Residential Services
Medical Residential Services
Orientation and Mobility Services for Impaired Vision
Personal Assistance
Personal Emergency Response Systems
Semi Independent Living
Supported Living

Transitional Case Management

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**25692367.05**
Residential Habilitation	Day	721	321.00	107.05	**24775759.05**	
Residential Habilitation Special Needs Adjustment	Day	154	248.00	24.00	**916608.00**	
Respite Total:						**761880.00**
Respite Sitter	15 minutes	24	315.00	3.76	**28425.60**	
Respite Overnight	Day	210	16.00	218.29	**733454.40**	
Support Coordination Total:						**14185572.48**
Support Coordination	Month	5072	12.00	233.07	**14185572.48**	
Nursing Services Total:						**4706230.00**
RN	15 minutes	2	240.00	8.50	**4080.00**	
LPN	15 minutes	157	5000.00	5.99	**4702150.00**	
Nutrition Services Total:						**409823.25**
Other Service	Visit	835	4.00	102.15	**341181.00**	
Assessment and Plan Development	Visit	285	1.00	240.85	**68642.25**	
Occupational Therapy Total:						**1269283.20**
Therapy	15 minutes	510	118.00	20.14	**1212025.20**	
Assessment and Plan Devlopment	Day	180	1.00	318.10	**57258.00**	
Physical Therapy Total:						**954807.20**
Assessment and Plan Devlopment	Day	260	1.00	317.72	**82607.20**	
Therapy	15 minutes	490	89.00	20.00	**872200.00**	
Specialized Medical Equipment and Supplies and Assistive Technology Total:						**142375.00**

Specialized Medical Equipment and Supplies and Assistive Technology	Item	85	1.00	1675.00	**142375.00**	
Speech, Language, and Hearing Services Total:						**1531115.00**
Other Service	15 MInutes	725	104.00	19.00	**1432600.00**	
Assessment and Plan Development	Day	305	1.00	323.00	**98515.00**	
Adult Dental Services Total:						**3421064.00**
Adult Dental Services	Procedure	2536	19.00	71.00	**3421064.00**	
Behavior Services Total:						**5334153.50**
Behavior Specialist	15 minutes	11	312.00	6.75	**23166.00**	
Behavior Analyst	15 minutes	1150	245.00	18.85	**5310987.50**	
Behavioral Respite Services Total:						**282802.52**
Behavioral Respite Services	Day	22	26.00	494.41	**282802.52**	
Employment and Day Services Total:						**70344819.43**
Facility-Based Day	Day	2105	75.00	47.60	**7514850.00**	
Community-Based Day	Day	4210	175.00	75.73	**55794077.50**	
In-home Day	Day	1263	10.00	72.18	**911633.40**	
Supported Employment	Day	1053	69.00	84.29	**6124258.53**	
Environmental Accessibility Modifications Total:						**250000.00**
Environmental Accessibility Modifications	Modification	25	1.00	10000.00	**250000.00**	
Family Model Residential Support Total:						**13184316.00**
Family Model Residential Support	Day	306	334.00	129.00	**13184316.00**	
Individual Transportation Services Total:						**1017629.25**
Individual Transportation Services	Day	865	165.00	7.13	**1017629.25**	
Intensive Behavioral Residential Services Total:						**285210.00**
Intensive Behavioral Residential Services	Day	2	300.00	475.35	**285210.00**	
Medical Residential Services Total:						**200172.00**
Medical Residential Services	Day	2	300.00	333.62	**200172.00**	
Orientation and Mobility Services for Impaired Vision Total:						**49242.00**
Assessment and Plan Development	Day	15	1.00	284.00	**4260.00**	
Other Service	15 minutes	21	119.00	18.00	**44982.00**	

Personal Assistance Total:						**30897574.40**
Personal Assistance	15 minutes	1160	7084.00	3.76	**30897574.40**	
Personal Emergency Response Systems Total:						**4720.00**
Monitoring	Month	8	12.00	45.00	**4320.00**	
Installation and Testing	Event	2	1.00	200.00	**400.00**	
Semi Independent Living Total:						**309834.40**
Semi Independent Living	Month	20	12.00	927.98	**222715.20**	
Semi-Independent Living Incentive Payment	Episode	20	1.00	2500.00	**50000.00**	
Semi-Independent Living Transition Payment	Episode	20	1.00	1855.96	**37119.20**	
Supported Living Total:						**184773948.00**
Supported Living	Day	2465	330.00	219.84	**178828848.00**	
Supported Living Special Needs Adjustment	Day	745	228.00	35.00	**5945100.00**	
Transitional Case Management Total:						**5400.00**
Transitional Case Management	Episode	4	1.00	1350.00	**5400.00**	
				GRAND TOTAL:		**360014338.68**
				Total Estimated Unduplicated Participants:		**5072**
				Factor D (Divide total by number of participants):		**70980.75**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**25692367.05**
Residential Habilitation	Day	721	321.00	107.05	**24775759.05**	
Residential Habilitation Special Needs Adjustment	Day	154	248.00	24.00	**916608.00**	
Respite Total:						**761880.00**
Respite Sitter	15 minutes	24	315.00	3.76	**28425.60**	
Respite Overnight	Day	210	16.00	218.29	**733454.40**	

Support Coordination Total:						**14185572.48**
Support Coordination	Month	5072	12.00	233.07	**14185572.48**	
Nursing Services Total:						**4706230.00**
RN	15 minutes	2	240.00	8.50	**4080.00**	
LPN	15 minutes	157	5000.00	5.99	**4702150.00**	
Nutrition Services Total:						**409823.25**
Other Service	Visit	835	4.00	102.15	**341181.00**	
Assessment and Plan Development	Visit	285	1.00	240.85	**68642.25**	
Occupational Therapy Total:						**1269283.20**
Therapy	15 minutes	510	118.00	20.14	**1212025.20**	
Assessment and Plan Devlopment	Day	180	1.00	318.10	**57258.00**	
Physical Therapy Total:						**954807.20**
Assessment and Plan Devlopment	Day	260	1.00	317.72	**82607.20**	
Therapy	15 minutes	490	89.00	20.00	**872200.00**	
Specialized Medical Equipment and Supplies and Assistive Technology Total:						**142375.00**
Specialized Medical Equipment and Supplies and Assistive Technology	Item	85	1.00	1675.00	**142375.00**	
Speech, Language, and Hearing Services Total:						**1531115.00**
Other Service	15 MInutes	725	104.00	19.00	**1432600.00**	
Assessment and Plan Development	Day	305	1.00	323.00	**98515.00**	
Adult Dental Services Total:						**3421064.00**
Adult Dental Services	Procedure	2536	19.00	71.00	**3421064.00**	
Behavior Services Total:						**5334153.50**
Behavior Specialist	15 minutes	11	312.00	6.75	**23166.00**	
Behavior Analyst	15 Minutes	1150	245.00	18.85	**5310987.50**	
Behavioral Respite Services Total:						**282802.52**
Behavioral Respite Services	Day	22	26.00	494.41	**282802.52**	
Employment and Day Services Total:						**70344819.43**
Facility-Based Day	Day	2105	75.00	47.60	**7514850.00**	
Community-Based Day	Day	4210	175.00	75.73	**55794077.50**	
In-home Day	Day	1263	10.00	72.18	**911633.40**	

Supported Employment	Day	1053	69.00	84.29	**6124258.53**	
Environmental Accessibility Modifications Total:						**250000.00**
Environmental Accessibility Modifications	Modification	25	1.00	10000.00	**250000.00**	
Family Model Residential Support Total:						**13184316.00**
Family Model Residential Support	Day	306	334.00	129.00	**13184316.00**	
Individual Transportation Services Total:						**1017629.25**
Individual Transportation Services	Day	865	165.00	7.13	**1017629.25**	
Intensive Behavioral Residential Services Total:						**285210.00**
Intensive Behavioral Residential Services	Day	2	300.00	475.35	**285210.00**	
Medical Residential Services Total:						**200172.00**
Medical Residential Services	Day	2	300.00	333.62	**200172.00**	
Orientation and Mobility Services for Impaired Vision Total:						**49242.00**
Assessment and Plan Development	Day	15	1.00	284.00	**4260.00**	
Other Service	15 minutes	21	119.00	18.00	**44982.00**	
Personal Assistance Total:						**30897574.40**
Personal Assistance	15 minutes	1160	7084.00	3.76	**30897574.40**	
Personal Emergency Response Systems Total:						**4720.00**
Monitoring	Month	8	12.00	45.00	**4320.00**	
Installation and Testing	Event	2	1.00	200.00	**400.00**	
Semi Independent Living Total:						**309834.40**
Semi Independent Living	Month	20	12.00	927.98	**222715.20**	
Semi-Independent Living Incentive Payment	Episode	20	1.00	2500.00	**50000.00**	
Semi-Independent Living Transition Payment	Episode	20	1.00	1855.96	**37119.20**	
Supported Living Total:						**184773948.00**
Supported Living	Day	2465	330.00	219.84	**178828848.00**	
Supported Living Special Needs Adjustment	Day	745	228.00	35.00	**5945100.00**	
Transitional Case Management Total:						**5400.00**
Transitional Case Management	Episode	4	1.00	1350.00	**5400.00**	
				GRAND TOTAL:		**360014338.68**
				Total Estimated Unduplicated Participants:		**5072**
				Factor D (Divide total by number of participants):		**70980.75**

Average Length of Stay on the Waiver:	356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**25692367.05**
Residential Habilitation	Day	721	321.00	107.05	**24775759.05**	
Residential Habilitation Special Needs Adjustment	Day	154	248.00	24.00	**916608.00**	
Respite Total:						**761880.00**
Respite Sitter	15 minutes	24	315.00	3.76	**28425.60**	
Respite Overnight	Day	210	16.00	218.29	**733454.40**	
Support Coordination Total:						**14185572.48**
Support Coordination	Month	5072	12.00	233.07	**14185572.48**	
Nursing Services Total:						**4706230.00**
RN	15 minutes	2	240.00	8.50	**4080.00**	
LPN	15 minutes	157	5000.00	5.99	**4702150.00**	
Nutrition Services Total:						**409823.25**
Other Service	Visit	835	4.00	102.15	**341181.00**	
Assessment and Plan Development	Visit	285	1.00	240.85	**68642.25**	
Occupational Therapy Total:						**1269283.20**
Therapy	15 minutes	510	118.00	20.14	**1212025.20**	
Assessment and Plan Devlopment	Day	180	1.00	318.10	**57258.00**	
Physical Therapy Total:						**954807.20**
Assessment and Plan Devlopment	Day	260	1.00	317.72	**82607.20**	
Therapy	15 minutes	490	89.00	20.00	**872200.00**	
Specialized Medical Equipment and Supplies and Assistive Technology						**142375.00**

Total:						
Specialized Medical Equipment and Supplies and Assistive Technology	Item	85	1.00	1675.00	**142375.00**	
Speech, Language, and Hearing Services Total:						**1531115.00**
Other Service	15 MInutes	725	104.00	19.00	**1432600.00**	
Assessment and Plan Development	Day	305	1.00	323.00	**98515.00**	
Adult Dental Services Total:						**3421064.00**
Adult Dental Services	Procedure	2536	19.00	71.00	**3421064.00**	
Behavior Services Total:						**5334153.50**
Behavior Specialist	15 minutes	11	312.00	6.75	**23166.00**	
Behavior Analyst	15 minutes	1150	245.00	18.85	**5310987.50**	
Behavioral Respite Services Total:						**282802.52**
Behavioral Respite Services	Day	22	26.00	494.41	**282802.52**	
Employment and Day Services Total:						**70344819.43**
Facility-Based Day	Day	2105	75.00	47.60	**7514850.00**	
Community-Based Day	Day	4210	175.00	75.73	**55794077.50**	
In-home Day	Day	1263	10.00	72.18	**911633.40**	
Supported Employment	Day	1053	69.00	84.29	**6124258.53**	
Environmental Accessibility Modifications Total:						**250000.00**
Environmental Accessibility Modifications	Modification	25	1.00	10000.00	**250000.00**	
Family Model Residential Support Total:						**13184316.00**
Family Model Residential Support	Day	306	334.00	129.00	**13184316.00**	
Individual Transportation Services Total:						**1017629.25**
Individual Transportation Services	Day	865	165.00	7.13	**1017629.25**	
Intensive Behavioral Residential Services Total:						**285210.00**
Intensive Behavioral Residential Services	Day	2	300.00	475.35	**285210.00**	
Medical Residential Services Total:						**200172.00**
Medical Residential Services	Day	2	300.00	333.62	**200172.00**	
Orientation and Mobility Services for Impaired Vision Total:						**49242.00**
Assessment and Plan Development	Day	15	1.00	284.00	**4260.00**	
Other Service	15 minutes	21	119.00	18.00	**44982.00**	

Personal Assistance Total:						**30897574.40**
Personal Assistance	15 minutes	1160	7084.00	3.76	**30897574.40**	
Personal Emergency Response Systems Total:						**4720.00**
Monitoring	Month	8	12.00	45.00	**4320.00**	
Installation and Testing	Event	2	1.00	200.00	**400.00**	
Semi Independent Living Total:						**309834.40**
Semi Independent Living	Month	20	12.00	927.98	**222715.20**	
Semi-Independent Living Incentive Payment	Episode	20	1.00	2500.00	**50000.00**	
Semi-Independent Living Transition Payment	Episode	20	1.00	1855.96	**37119.20**	
Supported Living Total:						**184773948.00**
Supported Living	Day	2465	330.00	219.84	**178828848.00**	
Supported Living Special Needs Adjustment	Day	745	228.00	35.00	**5945100.00**	
Transitional Case Management Total:						**5400.00**
Transitional Case Management	Episode	4	1.00	1350.00	**5400.00**	
				GRAND TOTAL:		**360014338.68**
				Total Estimated Unduplicated Participants:		**5072**
				Factor D (Divide total by number of participants):		**70980.75**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**25692367.05**
Residential Habilitation	Day	721	321.00	107.05	**24775759.05**	
Residential Habilitation Special Needs Adjustment	Day	154	248.00	24.00	**916608.00**	
Respite Total:						**761880.00**
Respite Sitter	15 minutes	24	315.00	3.76	**28425.60**	
Respite Overnight	Day	210	16.00	218.29	**733454.40**	

Support Coordination Total:						**14185572.48**
Support Coordination	Month	5072	12.00	233.07	**14185572.48**	
Nursing Services Total:						**4706230.00**
RN	15 minutes	2	240.00	8.50	**4080.00**	
LPN	15 minutes	157	5000.00	5.99	**4702150.00**	
Nutrition Services Total:						**409823.25**
Other Service	Visit	835	4.00	102.15	**341181.00**	
Assessment and Plan Development	Visit	285	1.00	240.85	**68642.25**	
Occupational Therapy Total:						**1269283.20**
Therapy	15 minutes	510	118.00	20.14	**1212025.20**	
Assessment and Plan Devlopment	Day	180	1.00	318.10	**57258.00**	
Physical Therapy Total:						**954807.20**
Assessment and Plan Devlopment	Day	260	1.00	317.72	**82607.20**	
Therapy	15 minutes	490	89.00	20.00	**872200.00**	
Specialized Medical Equipment and Supplies and Assistive Technology Total:						**142375.00**
Specialized Medical Equipment and Supplies and Assistive Technology	Item	85	1.00	1675.00	**142375.00**	
Speech, Language, and Hearing Services Total:						**1531115.00**
Other Service	15 MInutes	725	104.00	19.00	**1432600.00**	
Assessment and Plan Development	Day	305	1.00	323.00	**98515.00**	
Adult Dental Services Total:						**3421064.00**
Adult Dental Services	Procedure	2536	19.00	71.00	**3421064.00**	
Behavior Services Total:						**5334153.50**
Behavior Specialist	15 minutes	11	312.00	6.75	**23166.00**	
Behavior Analyst	15 minutes	1150	245.00	18.85	**5310987.50**	
Behavioral Respite Services Total:						**282802.52**
Behavioral Respite Services	Day	22	26.00	494.41	**282802.52**	
Employment and Day Services Total:						**70344819.43**
Facility-Based Day	Day	2105	75.00	47.60	**7514850.00**	
Community-Based Day	Day	4210	175.00	75.73	**55794077.50**	
In-home Day	Day	1263	10.00	72.18	**911633.40**	

Supported Employment	Day	1053	69.00	84.29	**6124258.53**	
Environmental Accessibility Modifications Total:						**250000.00**
Environmental Accessibility Modifications	Modification	25	1.00	10000.00	**250000.00**	
Family Model Residential Support Total:						**13184316.00**
Family Model Residential Support	Day	306	334.00	129.00	**13184316.00**	
Individual Transportation Services Total:						**1017629.25**
Individual Transportation Services	Day	865	165.00	7.13	**1017629.25**	
Intensive Behavioral Residential Services Total:						**285210.00**
Intensive Behavioral Residential Services	Day	2	300.00	475.35	**285210.00**	
Medical Residential Services Total:						**200172.00**
Medical Residential Services	Day	2	300.00	333.62	**200172.00**	
Orientation and Mobility Services for Impaired Vision Total:						**49242.00**
Assessment and Plan Development	Day	15	1.00	284.00	**4260.00**	
Other Service	15 minutes	21	119.00	18.00	**44982.00**	
Personal Assistance Total:						**30897574.40**
Personal Assistance	15 minutes	1160	7084.00	3.76	**30897574.40**	
Personal Emergency Response Systems Total:						**4720.00**
Monitoring	Month	8	12.00	45.00	**4320.00**	
Installation and Testing	Event	2	1.00	200.00	**400.00**	
Semi Independent Living Total:						**309834.40**
Semi Independent Living	Month	20	12.00	927.98	**222715.20**	
Semi-Independent Living Incentive Payment	Episode	20	1.00	2500.00	**50000.00**	
Semi-Independent Living Transition Payment	Episode	20	1.00	1855.96	**37119.20**	
Supported Living Total:						**184773948.00**
Supported Living	Day	2465	330.00	219.84	**178828848.00**	
Supported Living Special Needs Adjustment	Day	745	228.00	35.00	**5945100.00**	
Transitional Case Management Total:						**5400.00**
Transitional Case Management	Episode	4	1.00	1350.00	**5400.00**	
				GRAND TOTAL:		**360014338.68**
				Total Estimated Unduplicated Participants:		**5072**
				Factor D (Divide total by number of participants):		**70980.75**

Average Length of Stay on the Waiver:	356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**25692367.05**
Residential Habilitation	Day	721	321.00	107.05	**24775759.05**	
Residential Habilitation Special Needs Adjustment	Day	154	248.00	24.00	**916608.00**	
Respite Total:						**761880.00**
Respite Sitter	15 minutes	24	315.00	3.76	**28425.60**	
Respite Overnight	Day	210	16.00	218.29	**733454.40**	
Support Coordination Total:						**14185572.48**
Support Coordination	Month	5072	12.00	233.07	**14185572.48**	
Nursing Services Total:						**4706230.00**
RN	15 minutes	2	240.00	8.50	**4080.00**	
LPN	15 minutes	157	5000.00	5.99	**4702150.00**	
Nutrition Services Total:						**409823.25**
Other Service	Visit	835	4.00	102.15	**341181.00**	
Assessment and Plan Development	Visit	285	1.00	240.85	**68642.25**	
Occupational Therapy Total:						**1269283.20**
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Assessment and Plan Devlopment	Day	180	1.00	318.10	**57258.00**	
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Therapy	15 minutes	490	89.00	20.00	**872200.00**	
Specialized Medical Equipment and Supplies and Assistive Technology						**142375.00**

Total:						
Specialized Medical Equipment and Supplies and Assistive Technology	Item	85	1.00	1675.00	**142375.00**	
Speech, Language, and Hearing Services Total:						**1531115.00**
Other Service	15 MInutes	725	104.00	19.00	**1432600.00**	
Assessment and Plan Development	Day	305	1.00	323.00	**98515.00**	
Adult Dental Services Total:						**3421064.00**
Adult Dental Services	Procedure	2536	19.00	71.00	**3421064.00**	
Behavior Services Total:						**5334153.50**
Behavior Specialist	15 minutes	11	312.00	6.75	**23166.00**	
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Behavioral Respite Services Total:						**282802.52**
Behavioral Respite Services	Day	22	26.00	494.41	**282802.52**	
Employment and Day Services Total:						**70344819.43**
Facility-Based Day	Day	2105	75.00	47.60	**7514850.00**	
Community-Based Day	Day	4210	175.00	75.73	**55794077.50**	
In-home Day	Day	1263	10.00	72.18	**911633.40**	
Supported Employment	Day	1053	69.00	84.29	**6124258.53**	
Environmental Accessibility Modifications Total:						**250000.00**
Environmental Accessibility Modifications	Modification	25	1.00	10000.00	**250000.00**	
Family Model Residential Support Total:						**13184316.00**
Family Model Residential Support	Day	306	334.00	129.00	**13184316.00**	
Individual Transportation Services Total:						**1017629.25**
Individual Transportation Services	Day	865	165.00	7.13	**1017629.25**	
Intensive Behavioral Residential Services Total:						**285210.00**
Intensive Behavioral Residential Services	Day	2	300.00	475.35	**285210.00**	
Medical Residential Services Total:						**200172.00**
Medical Residential Services	Day	2	300.00	333.62	**200172.00**	
Orientation and Mobility Services for Impaired Vision Total:						**49242.00**
Assessment and Plan Development	Day	15	1.00	284.00	**4260.00**	
Other Service	15 minutes	21	119.00	18.00	**44982.00**	

Personal Assistance Total:						**30897574.40**
Personal Assistance	15 minutes	1160	7084.00	3.76	**30897574.40**	
Personal Emergency Response Systems Total:						**4720.00**
Monitoring	Month	8	12.00	45.00	**4320.00**	
Installation and Testing	Event	2	1.00	200.00	**400.00**	
Semi Independent Living Total:						**309834.40**
Semi Independent Living	Month	20	12.00	927.98	**222715.20**	
Semi-Independent Living Incentive Payment	Episode	20	1.00	2500.00	**50000.00**	
Semi-Independent Living Transition Payment	Episode	20	1.00	1855.96	**37119.20**	
Supported Living Total:						**184773948.00**
Supported Living	Day	2465	330.00	219.84	**178828848.00**	
Supported Living Special Needs Adjustment	Day	745	228.00	35.00	**5945100.00**	
Transitional Case Management Total:						**5400.00**
Transitional Case Management	Episode	4	1.00	1350.00	**5400.00**	

GRAND TOTAL:	**360014338.68**
Total Estimated Unduplicated Participants:	**5072**
Factor D (Divide total by number of participants):	**70980.75**
Average Length of Stay on the Waiver:	356