

Statewide Waiver Individual Cost Neutrality Cap

Frequently Asked Questions

Providers and Independent Support Coordinators

Why is there an individual cost neutrality cap?

The cap is being implemented in order to serve more people in a more cost-effective manner.

How much is the individual cost neutrality cap and how was the amount determined?

The cap for 2015 is \$153,416.80 and is based on the average annual cost of services in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) in Tennessee. This amount is determined by the State Comptroller's Office. The new cap is higher than the average cost of services in the Arlington waiver today, nearly twice the average cost of services in the Statewide waiver today, and nearly 4 times the national average cost of providing HCBS to the I/DD population.

Is the individual cost neutrality cap based on waiver year or ISP year?

The cap will be applied on both the waiver (or calendar) year and ISP year. The total paid waiver services cannot exceed the cap in either year for a person supported.

Upon implementation of the cap, will the person supported need a new ISP?

No. Persons will not need a new ISP. This includes people transferring from the Statewide Waiver into the CAC Waiver.

Is the amount of the cap permanent?

No. The cap amount will change every year, based on the new average cost of private ICF/IID services in Tennessee. That amount is set by the State Comptroller's Office. ISCs should make sure that persons supported in the Statewide waiver are informed of the cost cap amount each year.

This does not mean that each person in the Statewide waiver can select services up to the individual cap amount. That would undermine the reason for establishing an individual cap, which is to provide services more cost-effectively so that more people with intellectual and developmental disabilities can be served. Rather, the amount of services each person receives should be based on an individualized assessment of the services and supports needed by the person to live safely in the community and to pursue individual employment, habilitation, and other integrated community living goals. Once the needs are determined, a person should help to select the services and settings in which these services will be provided, as well as their providers, working *within* the covered benefits available in the waiver and *within* the individual cost cap.

Do state funded services count against the cap?

No. State funded services are not included in the cap calculation.

Will medical residential services and intensive behavioral residential services (IBRS) be available to people in the Statewide waiver?

Yes, these benefits continue to be covered in the Statewide waiver. We will be working with providers to make them available within the cost cap.

Medical residential services in a 4-person home can be reimbursed within the cap.

Intensive behavioral residential services can also be provided within the cap in a manner consistent with the intent of the service, i.e., a short-term treatment model with the goal of helping the person transition to a more integrated setting. IBRS is not an indefinite, long term, residential support service. A person in the Statewide waiver could receive IBRS as needed to help address facilitate transition to a more integrated setting. With the implementation of the new TennCare Behavioral Crisis Prevention, Intervention and Stabilization Service for individuals with intellectual or developmental disabilities, we believe we will be able to put together a package of supports that will allow individuals enrolled in the Statewide waiver who have significant behavioral challenges to be safely supported in the community.

Do provider incentive payments count against the individual cost neutrality cap?

No. The incentive payments to providers for persons in the Statewide waiver who are transitioning from a 24/7 residential service to Semi-Independent Living Services and the employment incentives will not count against the person's individual cost neutrality cap.

How will the process work when there is a service request?

Each night, using all available data, DIDD will calculate the total cost of waiver services for everyone in the Statewide Waiver. For each person, these will include:

1. Current ISP Year Cap
2. Past/Future ISP Year Cap (if applicable)
3. Current Waiver (Calendar) Year Cap
4. Past/Future Waiver (Calendar) Year Cap (if applicable)

This information will be pushed to each Regional Office CS Tracking application each night. When service requests are entered into CS Tracking, the system will look to these numbers to determine if the request is still under the cap in both the ISP Year and Waiver Year. If either of these calculations (Waiver or ISP year) is over the cap, the appropriate message will be displayed and the request will not be allowed to be saved.

A notice will be sent to the person supported, advising them of the specific services that have been denied and the reason, i.e., that the services would exceed the cost cap, and the right to file an appeal. Fair hearings will be granted when there is a dispute regarding whether such services would in fact result in the cap being exceeded and in accordance with policy and rules surrounding the cap. Fair hearings will not be granted for people who want or believe they need services in excess of the cap.

Additionally, various regional office personnel will have access to a Crystal Report to get anyone's total cost of waiver services at any time. Prior to Plans Review/Data Entry, the total cost of waiver services for the person involved can be displayed on a report.

How is the total cost of a person's services determined?

The total cost of a person's waiver services will be calculated using a combination of actual paid dollars and service projections based on services authorized but not yet billed.

Once the service date is older than 13 weeks, it can no longer be billed or adjusted except under special circumstances. So, for the period of time that billing is closed, actual paid dollars will be used.

For the period of time from the first Calendar Open Date of PCP to the end of the year (ISP or Waiver), the Maximum Billable Amount of the authorizations will be used. DIDD will assume that 100 percent of the services that can be billed will be billed.

Will multiple authorizations, such as for Day Services, count against the cap?

No. If multiple authorizations are in effect, the most expensive one will be counted in the person's total cost of waiver services. Once PCP is closed to those dates, the actual paid amount will be used. So, if lesser services were billed and paid, the total cost of waiver services calculation will adjust accordingly.

How will ISCs know what a person's total cost of waiver services is when they need to develop an annual ISP or submit an amendment?

DIDD will burst a Crystal Report to each ISC each month that will include an up-to-date calculation of the total cost of waiver services for each person they are responsible for. This Crystal Report burst will be similar to the ISP Expiration Date Report burst DIDD already completes monthly.

Will providers be given information about the total cost of waiver services for people they support?

Yes. You will receive this information upon approval and implementation of the waivers. After that, a person's ISC will receive this cost information monthly.

Are rates changing upon approval of the CAC and Statewide waiver?

No rate changes are scheduled to start with the implementation of the CAC and Statewide waiver.

How will recoupments affect cap tracking?

Until payments are actually recouped, the amount "paid" will still count against the total cost of waiver services. Once recouped, the maximum billable amount will be adjusted to reflect the recoupment.

What kind of planning needs to happen for a person transitioning from one provider to another to stay within the individual cost neutrality cap?

Individuals transitioning within the community have established cost plans and payments from their existing services. The ISC and Regional Office will have the up-to-date cap information for this person. As the transition plan is created, this existing cap information must be referenced to make sure that the difference of new and discontinued services keeps the person under the individual cost neutrality cap.

If residential services are involved with multiple persons residing at the same site, the individuals remaining in the original location are also part of the transition process. Their cap numbers must also be considered. It is the responsibility of the Residential Provider to notify the ISC for all individuals in that home that a move (in or out of the home) may occur to ensure appropriate planning for all individuals in the home. This includes both individuals receiving DIDD waiver services and CHOICES services. In accordance with policy, these changes must be communicated promptly to the Regional Office.

Can a person private pay a portion of their services to stay under the cost neutrality cap?

Yes. Services above the cap are not covered under the waiver. If a person and/or their family members choose to purchase these non-covered services privately from a provider, this has no impact on the individual cost neutrality cap. Waiver services paid for by TennCare are the only services that will impact the individual cost neutrality cap.