

#	COMMENT	SOURCE	POLICY SECTION	DIDD RESPONSE
1	Thank you for not asking for duplicate documentation!	Betty McNeely, Journeys in Community Living	VI.B.(3)	You're welcome.
2	We recommend that the waiting period be reduced to 15 days.	Betty McNeely, Journeys in Community Living	VI.C.(1)	We appreciate the recommendation. A timeline of 15 calendar days is not feasible given DIDD's staffing resources.
3	Agencies report that in the past DIDD has been somewhat slow in sending out the site codes and agreement amendment.	Betty McNeely, Journeys in Community Living	VI.C.(13)(d.)	Your comment is noted.
4	How far back will this historical review go? We assume that a good track record over recent years (last three?) will be sufficient.	Betty McNeely, Journeys in Community Living	VI.D. (1-9)	The historical review encompasses the entire length of time the agency has been contracted with DIDD to provide waiver services and supports.
5	Found by whom? Through a DIDD investigation?	Betty McNeely, Journeys in Community Living	VI.E.(1)(b.)	Found can be interpreted broadly. The discovery may be revealed during an investigation by another entity, e.g., local law enforcement, TennCare or DIDD Protection from Harm investigation. The key point is that if a provider retaliates against a person supported, family or staff member for involvement in a complaint, investigation or appeal, that provider agency will be disqualified from consideration or reapplication. Note that State and federal statutes are pertinent to the complaint, investigation and appeal processes. Retaliation against someone involved in any of the aforementioned processes is strictly prohibited.
6	This seems a little vague-how negative is "negative"?	Betty McNeely, Journeys in Community Living	VI.E.(1)(h)(iii)	Concur. The policy has been revised to read as follows: "Reviews of any other reports that may include Fiscal Accountability Reviews as well as any review pertinent to the health and safety of persons receiving services."

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1	There is widespread confusion over how the “total projected cost of waiver services” will be arrived at, especially for persons who wish to receive a variety of day (SE, FB, CB, In-home) services. Has a spread sheet been developed for ISC use? If so, could it also be given to providers?	Betty McNeely, Journeys in Community Living	VI.A.(4)	<p>The cap limits apply to both the Waiver Year and ISP Year so there will always be past payments that need to be included in the calculation. As this payment data (dollars and units) involves many providers it is not available to any single provider in a format that could be used to do a Maximum Billable Amount (MBA) Cap calculation. Without that information no spreadsheet could possibly supply an accurate answer. So, no spreadsheet tool is available. Manually calculating an MBA Cap number is an intricate and detailed effort that requires several data sources and a full understanding of all service authorization rules and limits. All cap numbers are calculated for each Statewide Waiver person each night at DIDD Central Office and these are available to the Regional Offices each morning.</p> <p>As for calculating the accurate MBA when there are multiple Day Services, first we use what has actually been billed. For all future services our mathematical algorithm uses the 5 highest claims per calendar week up to 243 units in the Waiver year (if the cost plans support that). These are the waiver maximums for Day Services.</p>
2	Providers should be included in the list of team members.	Betty McNeely, Journeys in Community Living	VI.C.(1)	At a minimum, the team consists of the person supported, legal representative (if applicable), and ISC/CM. Providers are also a part of the planning team, as identified by the person supported. According to the CMS Person-Centered Planning rule, “The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process.”

3	Procedures for emergency requests and their timelines should be specified in this policy.	Betty McNeely, Journeys in Community Living	VI.C.(3)	This issue was discussed and the decision was made to dedicate a separate policy to emergency requests for services. The reason is that emergency requests may be submitted for reasons other than authorization of waiver services. Therefore, the DIDD staff responsible for performing the work believed it was important to dedicate a policy specifically to emergency requests for services.
4	Adverse action-does not specify who is to be informed. We assume the provider will be included.	Betty McNeely, Journeys in Community Living	VI.C.(3)	The Department abides by the Grier Revised Consent Decree and TennCare guidelines pertaining to appeals. The advance notice is disseminated to the person supported and legal representative (if applicable).
5	The timeframe is confusing. Ten days is listed here; 14 days under D. (1) (or does that just refer to denials upon appeal?)	Betty McNeely, Journeys in Community Living	VI.C.(3)	Advance notices of adverse action have a minimum requirement of 10 days advance notice and 5 days mail time in accordance with Grier. D.1. regards an initial notice of adverse action-the 14 day review timeframe is correct.
6	The provider of effected services should also be notified within this time frame.	Betty McNeely, Journeys in Community Living	VI.D.(1)	Your comment is noted.
7	Unclear whether or not existing service will continue if an amendment is denied.	Betty McNeely, Journeys in Community Living	VI.E.(1)	The additional service(s) submitted in an amended ISP would be the only thing denied-current services would continue.
8	Again, the provider should receive notice.	Betty McNeely, Journeys in Community Living	VI.E.(2)	Your comment is noted.

9	We do not understand the draconian approach here. Why not just continue the services that had been previously approved rather than disenrolling someone altogether? What is “timely”?	Betty McNeely, Journeys in Community Living	VI.E.(4)	If the ISC submits an ISP or amendment in which the total projected cost of services exceeds the individual cost neutrality cap, and a compliant plan is not submitted timely then disenrolling the person from waiver services would be the absolute last resort. There are not any exceptions to the individual cost neutrality cap (cap). The cap was approved by CMS upon approval of the Statewide Waiver. The State cannot use waiver funds to reimburse providers for services in excess of the cap. State funds have not been appropriated to pay for services in excess of the individual cost neutrality cap. Thus, the State does not have a mechanism to pay providers for services in excess of the cap. It is vitally important that ISCs submit plans that are within the cap according to the timeline specified in policy 80.3.4 Authorization of Services, section VI.C.2.
10	Would not an emergency admittance to the CAC Waiver be both more sensible and more humane? What alternate services are available? If the person is disenrolled, what responsibility will DIDD assume to help procure services for the person? What responsibility will the provider have, especially in cases where the person is receiving residential services?	Betty McNeely, Journeys in Community Living	VI.E.(5)	Persons supported cannot transfer from the Statewide Waiver to the CAC Waiver. Alternate services include services available through the TennCare Managed Care Organization (MCO) for which the person is eligible and services for which the person and or family members are able or willing to pay. DIDD will attempt to identify alternate services for persons supported who cannot be safely supported through the waiver.

80.3.6 Amending the Initial Plan of Care Before Development of the ISP

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NA	None	NA	NA	There were not any comments submitted for this policy.