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

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

Waiver TN.0128.R07.00

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

Waiver TN.0357.R05.00

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

TN.0427.R04.00

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

The currently approved waiver applications are available here: Persons with Intellectual Disabilities Receiving Services in the 1915(c) HCBS Waivers (tn.gov)

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

The requested effective date of these changes is January 1, 2025.

The primary purpose of these waiver submissions is to submit the SW, CAC, and SD Waiver Applications for a renewal period of five years and to **resubmit** the changes **not** related to 1915(c) integration into managed care that were submitted to the Centers for Medicare and Medicaid Services (CMS) in September/November 2022.

The I/DD integration amendments/renewal, including most of the proposed non-integration related changes below, were previously posted for public comment on February 19, 2021 and July 29, 2022. If you previously submitted comments related to these changes in 2021/2022, it is not necessary to resubmit those comments again.

TennCare's previous public comment posting and responses to these public comments can be found at the following links:

ProposedRenewalAmendmentsToTennesseesSection1915c.pdf (tn.gov)

ResponsesPublicComment1915cRenewalAmendments.pdf (tn.gov)

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

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

- Clarifying in Appendix B-6 that in order to remain eligible for the waiver, a person must not only need, but actually *receive* ongoing waiver services.
  - "In order to be eligible for this waiver, the person must require a program of specialized services and but for the provision of those services, require the level of care provided in an ICF/IID. Accordingly, a person must receive at least one ongoing waiver service in addition to independent support coordination on an ongoing basis—at a minimum, quarterly."
- The introduction of a new Community Informed Choice process for waiver participants considering or seeking transfer from the waiver to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) in order to ensure an informed choice of services and settings through a process which identifies alternatives through which the individual could continue to be supported in the community, avoid unnecessary institutionalization, and receive services in the most integrated setting appropriate and clarifications regarding freedom of choice as it relates to choice of providers (Appendix B-7; freedom of choice of providers is detailed in

Appendix D-1(f) below)

- Person-centered updates in Support Coordination processes and expectations, including an Employment Informed Choice process (see Section II below).
- Adding consumer direction options for Statewide and CAC Waivers (see Section III below).
- Adjustments to Appendix C Waiver Services, as follows—see Attached Appendix C for additional detail, as applicable.
    - Revisions to the definition of Support Coordination services to reflect person-centered expectations aligned with program goals (detail attached)
    - Adjustments to Therapy (OT, PT, Speech, Language and Hearing), Behavior and Nutrition Services to add the following:
      As part of the provision of this service, licensed professionals shall be expected to teach, train and support paid and unpaid caregivers, embedding appropriate treatment within the day-to-day delivery of supports in order to maximize both the efficacy and efficiency of service delivery, and for developing a plan for fading direct services to the extent possible and appropriate.
      No additional changes are proposed for these benefits as part of these renewals.
    - Adjustments to Facility-Based Day Supports to reflect the following:
      Continued authorization of these services shall include an employment informed choice process to support the person in making an informed choice about work and other integrated service options.
    - Adjustments to all residential and day services and Personal Assistance to add the following:
      As part of the provision of this service, the provider shall be responsible for working with the person, the person's ISC and Circle of Support to explore how Enabling Technology could be used to support the person's achievement of individualized goals and outcomes and increase the person's independence in or across environments, including home, community, work, volunteering, and travel; helping to educate the person supported and his/her Conservator, as applicable and Circle of Support in order to ensure an informed choice regarding the potential use of Enabling Technology; and the implementation of Enabling Technology supports as part of the delivery of this service, as appropriate, when approved as part of the person's PCSP.
      No additional changes are proposed for these benefits as part of these renewals except as specified herein.
    - Deleting the following language from the Residential Habilitation, Family Model, and Supported Living service definitions in Appendix C-1 of the CAC and SW Waivers per CMS request:
        - ~~RNSA-HB will be available after April 1, 2019 or a later date.~~
    - Deleting the following language from the Facility-Based Day Supports, Community Participation, Intermittent Employment and Community Integration Wrap-Around Supports, Non-Residential Homebound Support Services, Supported Employment-Individual, and Supported Employment-Small Group service definitions in Appendix C-1 per CMS request:
        - ~~This service is available beginning January 1, 2020.~~
    - Deleting the Employment and Day Services service from Appendix C-1 of the SD waiver
- Adding the System for Award Management (SAM) background check requirement in Appendix C-2.a. Criminal History and/or Background Investigations, C-2.b. Abuse Registry Screening, and C-2.f. Open Enrollment of Providers
- Clarifications to the Grievance and Complaint process in Appendix F
- Changes in Appendix G to align critical incident management terms, definitions, and processes across HCBS programs—these are part of broader person-centered system alignment efforts advanced through I/DD integration, but these efforts precede discussions around I/DD integration (critical incident terminology is also changed to reportable event terminology as appropriate throughout the document).
- Slight adjustments in Appendix G pertaining to restraints (included in the above)
- Slight adjustments in Appendix G regarding performance measures, processes, and remediation pertaining to critical incidents and restraints
- Slight adjustments in Appendix H to clarify when a performance measure is reviewed for potential systemic remediation, i.e., based on an overall cumulative compliance percentage below 86% over a rolling 12-month period
- Throughout each waiver application, aligning the name used to refer to the plan of care with other HCBS programs: the Person-Centered Support Plan (or PCSP)
- Throughout each waiver application, minor adjustments to conform language across each of the three waivers (as applicable), where such conformity may have been inadvertently overlooked in previous submissions
- Updating references to Bureau of TennCare to Division of TennCare
- Correcting a reference to the "Howard" Jordan Center to "Harold" Jordan Center in the CAC Waiver

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

- Deleting obsolete references to intake and enrollment in the Self-Determination Waiver since enrollment into this waiver is closed
- Clarifying language in Appendix C-5: Home and Community-Based Settings per CMS request
- Deleting language in Appendix C, Quality Improvement: Qualified Providers related to performance measure QPa.i.b.1 (Number and percentage of non-licensed/non-certified providers who met waiver provider qualifications)
- Adding a new performance measure and related language in Appendix C, Quality Improvement: Qualified Providers to implement System for Award Management (SAM) as a new background check requirement for direct support staff.
- Adding a new performance measure and related language in Appendix D: Quality Improvement under Sub-Assurance a (Methods for Discovery: Service Plan Assurance/Sub-assurances) to address whether service plans meet the individual's needs as recommended by CMS
- Updating the sampling methodology in Appendix D: Quality Improvement for performance measure SPa.i.a.4 (Number and percentage of consumer satisfaction survey respondents who reported that the things important to them were addressed in their Person-Centered Support Plan) to reflect a calendar year stratified sample with a minimum seven percent (7%) completion across all waivers
- Moving performance measure HWa.i.1 (Number and percentage of waiver participants who received medical exams in accordance with TennCare Rules) in Appendix G: Quality Improvement from Sub-assurance a to Sub-assurance d per CMS request
- Adding a new performance measure and related language in Appendix G: Quality Improvement under Sub-Assurance a (Methods for Discovery: Health and Welfare) to address whether individuals know how to report abuse, neglect, and exploitation as recommended by CMS
- Updating the sampling methodology in Appendix G: Quality Improvement for HWa.i.2 (Number and percentage of participant satisfaction survey respondents who indicated knowledge of how to report a complaint), HWa.i.3 (Number and percentage of participant satisfaction survey respondents who reported being treated well by direct support staff), and HWa.i.4 (Number and percentage of participant satisfaction survey respondents who reported having sufficient privacy) to reflect a calendar year stratified sample with a minimum seven percent (7%) completion across all waivers
- Revising performance measure HWa.i.8 in Appendix G: Quality Improvement to reflect both DDA and provider level investigations by removing the "DIDD" specification
- Deleting the combined Employment and Day Services service from Appendix J of the SD Waiver

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

- Throughout each waiver application, updating all previous amendment/renewal date references to a renewal date of January 1, 2025
- Updating outdated references for DIDS (Division of Intellectual Disability Services) and DIDD (Department of Intellectual and Developmental Disabilities) to Department of Disability and Aging (DDA) to reflect the transition of the Tennessee Commission on Aging and Disability (TCAD) under the direct leadership of DIDD and the merging of the two organizations.
- Updating the cost limit in Appendix B-2 of the SD waiver, as well as the cost limit language in C-4 and E-2.
- Deleting performance measure LOCa.i.a.2 (initial LOC completed prior to enrollment) in Appendix B, Quality Improvement: Level of Care in the CAC waiver as the State's system does not allow for new enrollment without an initial LOC completed, thus there will never be an instance of non-compliance with this measure
- Adjustments to Appendix C: Participant Services including:
    - Updating the provider certification specifications for Benefits Counseling to refer to TennCare protocol.
    - Revising the provider licensure specifications for Enabling Technology
- Adding the TennCare Terminated Provider List (TTPL) background check requirement in Appendix C-2.a. Criminal History and/or Background Investigations, C-2.b. Abuse Registry Screening, and C-2.f. Open Enrollment of Providers. The State is also replacing Provider Performance Survey/Quality Assurance Survey references in these sections with Qualified Provider Reviews where applicable.
- Replacing Tennessee Sexual Offender Registry references in C-2.a., C-2.b., C-2.f., and throughout provider service specifications with National Sex Offender Registry
- Deleting language in Appendix C-4 and E-2 of the SD waiver regarding limits on sets of services to reduce service limitations

- Adjustments to Appendix C, Quality Improvement: Qualified Providers including:
    - With regard to Qualified Provider Reviews/Provider Performance Surveys, updating the review cycle from annually to 12-18 months in c.ii. and other sections as applicable, including the sampling methodology for applicable performance measures and provider specifications for each service
    - Adding new performance measures and related language to implement TTPL as a new background check requirement for direct support staff
- Updating the Data Source and related language for performance measures HWa.i.20 and HWa.i.21 in Appendix G, Quality Improvement to reflect Qualified Provider Reviews instead of Quality Assurance Surveys
- Slight revision to Utilization Review (UR) language in Appendix I-1 to clarify that URs are completed for providers with annual revenue of $500k and up.
- Adding Exploration for Individualized Integrated Employment (IIE) and Exploration for Self-Employment (SE) components and projections to the Exploration service in Appendix J-2.
- Submitting Appendix J projections for waiver years 2025 through 2029 of the SW, CAC, and SD waivers

Details regarding each of these changes follows below, as needed. Language in the CMS waiver application template sections is in blue font. Currently approved waiver language is in black font. Tracked changes representing the I/DD Integration amendment changes posted for public comment in 2021/2022 are shown in ~~struck through~~ red font for deleted text and violet underline font for new text. Tracked changes representing new proposed waiver changes that were NOT posted for public comment in 2021/2022 are in ~~struck through~~ pink font for deleted text and green underline font for new text.

Appendix A: Waiver Administration and Operation

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

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

TennCare is primarily responsible for policy making and DDA~~IDD~~ is responsible for implementation of policies and oversight.

TennCare exercises administrative authority and supervision of ~~these~~ operating functions delegated to DDA~~IDD~~ through the interagency agreement which is reviewed on an annual basis to ensure that it accurately reflects expectations and incorporates any program changes implemented as a result of recent waiver amendments or changes in state or federal requirements. ~~-~~TennCare promulgates state waiver rules and directs ~~approves~~ all documents pertaining to daily operational management of the waiver prior to their issuance and implementation, including (but not limited to): all ~~DIDD~~ policies and procedures~~, Provider Manual revisions~~, provider rate changes, and ~~mass~~ formal communications (e.g., notices) to providers and persons supported.

In addition to ongoing informal communication processes, ~~monthly~~ frequent meetings between TennCare and DDA~~IDD~~ ensure adequate TennCare oversight. ~~Monthly~~ These meetings include:

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

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

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

The State is deleting the following performance measure:

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.~~

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

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

Appendix B: Participant Services

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

The State is updating the cost limit below for the SD waiver:

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:

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

X The following dollar amount:

~~20000~~ 36000

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

The State is deleting the following performance measure from the CAC waiver:

~~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.~~

Appendix C: Participant Services

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

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

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

b. Abuse Registry Screening will be modified as follows:

The Tennessee Department of Health maintains the State's Abuse Registry under the authority of T.C.A. 68-11-1001, et seq. The provider agreement requires that each provider have background and registry checks completed for all new employees whose responsibilities include direct care for a person supported and any current employees who have a change in job responsibilities to include direct care for a person supported, prior to, but no more than 30 calendar days in advance of, employment or a change in duties. This requirement includes specifically: (1) an appropriate background check completed by either the Tennessee Bureau of Investigation or a company licensed by the state to conduct such checks; (2) a check of the Tennessee Department of Health Abuse Registry; (3) a check of the ~~Tennessee~~ National 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; (6) a check of the System for Award Management; and (7) a check of the TennCare Terminated Provider List.

The process for ensuring that these checks have been completed appropriately and timely is part of the ~~quality assurance survey~~ Qualified Provider Review process set forth in the waiver application (see performance measure a.i.a.6.).During the Qualified Provider Review ~~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).

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

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

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

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

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:

- 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~~ National Sexual Offender Registry, the Tennessee Felony Offender List, ~~or~~ the Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, or the TennCare Terminated Provider List.

Appendix C: Participant Services
Quality Improvement: Qualified Providers

The State is adding the following new performance measures:

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDA~~IDD~~ Qualified Provider Reviews

a.i.a.17. Newly employed/reassigned direct support staff serving waiver participants with System for Award Management (SAM) checks completed prior to, but no more than 30 calendar days in advance of employment, or reassignment to direct support. % =# of newly employed/reassigned DSS with timely SAM checks/total number of newly employed/reassigned DSS serving waiver participants.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☑ Monthly	☑ Less than 100% Review
☐ Other Specify:	☐ Quarterly	☐ Representative Sample Confidence Interval:
	☐ Annually	☐ Stratified
	☐ Continuously and Ongoing	☑ Other ~~100% annual review of agency providers; 100% biannual review of exceptional/ proficient agency providers~~ 100% of providers surveyed during the calendar year as part of the 18-month QM survey cycle

Commented [EI2]: This change will apply to all QP measures except QPaia1

	☐ Other Specify:	

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDA~~IDD~~ Qualified Provider Reviews

a.i.a.18. Newly employed/reassigned direct support staff serving waiver participants with TennCare Terminated Provider (TTPL) checks completed prior to, but no more than 30 calendar days in advance of employment, or reassignment to direct support. % =# of newly employed/reassigned DSS with timely TTPL checks/total number of newly employed/reassigned DSS serving waiver participants.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☑ Monthly	☐ Less than 100% Review
☐ Other Specify:	☐ Quarterly	☐ Representative Sample Confidence Interval:
	☐ Annually	☐ Stratified
	☐ Continuously and Ongoing	☑ Other 100% of providers surveyed during the calendar year as part of the 18-month QM survey cycle
	☐ Other Specify:	

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

Performance Measures a.i.a.4., a.i.a.5. through a.i.a.11., ~~a.i.b.1~~ and a.i.c.1.: Qualified Provider Reviews and Provider Performance Surveys are conducted recurrently as part of the 18-month Quality Monitoring survey cycle ~~annually for 100% of provider agencies who employ two (2) or more staff~~.

The State added a.i.a.17 and a.i.a.18 to reflect a new requirement that newly employed (or reassigned) direct support staff serving waiver participants (persons supported) have System for Award Management (SAM) and

TennCare Terminated Provider (TTPL) checks completed prior to, but no more than 30 calendar days in advance of employment, or a change in assignment to direct support.

b. Methods for Remediation/Fixing Individual Problems

Performance Measures a.i.a.5. through a.i.a.8., a.i.a.17, a.i.a.18, and a.i.c.1.: DDA~~IDD~~ will review a sample of provider agency staff personnel and training records during Qualified Provider Compliance Reviews. For individual direct support staff who did not have required training, at the time of the Qualified Provider review, DDA~~IDD~~ will require the provider agency to take appropriate personnel action(s).

Failure to obtain and maintain background or registry checks and/or staff training in accordance with state law and DDA~~IDD~~ 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.10.through a.i.a.11.: DDA~~IDD~~ will review a sample of provider agency staff personnel records during Qualified Provider Compliance Reviews.

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

Appendix C-4: Additional Limits on Amount of Waiver Services

Commented [EI3]: Changes apply to SD waiver only

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.

~~The home and community-based service provided through this waiver are intended to provide services and supports that are essential for participants to continue residing in their own or family homes and participate as members of their communities. The services are classified under two broad service categories: (a) the Supports for Community Living Service Category and (b) the Professional and Technical Supports Service Category. The Supports for Community Living Service Category includes the following services: Behavioral Respite Services, Respite, Personal Assistance, Supported Employment Individual Employment Supports, Supported Employment Small Group Employment Supports, Community Participation Supports, Intermittent Employment and Community Integration Wrap-Around Supports, Facility Based Day Supports, the Non-Residential Homebound Support Service, Semi-Independent Living Services, and Individual Transportation Services. A participant's use of any service or combination of services included in the Supports for Community Living Service Category is limited to $23,000 per year per participant unless an exception to the service limit has been approved. However, a waiver participant can exceed this limit if the sole reason the limit would be exceeded is a change in the reimbursement methodology that is required under the terms of the Statewide Transition Plan described in Attachment 2. of this waiver in order to achieve compliance with the federal HCBS Settings Rule.~~

~~The Professional and Technical Supports Service Category includes the following services: Occupational Therapy; Physical Therapy; Speech, Language and Hearing; Nursing; Specialized Medical Equipment and Supplies and Assistive Technology; Behavior Services; Environmental Accessibility Modifications; Personal Emergency Response System; Orientation and Mobility Services for Impaired Vision; Nutrition Services, and Adult Dental Services. A participant's use of any service or combination of services included in the Professional and Technical Supports Service Category is limited to $7,000 per year per participant unless an exception to the service limit has been approved.~~

~~The $23,000 per year per individual in the Supports for Community Living Category and $7,000 per year per individual in the Professional and Technical Support Services Category which are uniformly applied to all waiver participants were established with input from consumers, family members, and other stakeholders, as well as review of HCBS utilization in similar programs in other states in order to provide a wide array of services and an adequate level of home and community based services to sustain community living in the most integrated setting appropriate while assuring their health, safety and welfare. Over time, these limits have proven to be adequate as the average expenditures per person has been much lower than the applicable limits allow. The 372 report for year ending 2015 reported an average expenditure of $18,809 per person. Upon approval of this waiver renewal, the projected average expenditure is $21,324 per person for 2018.~~

~~An exception to the service limit in either category may be approved if the increased service limit is determined necessary to protect the participants' health and welfare, prevent the participant's admission to an institution or an exception is necessary to ensure that the participant receives services necessary to achieve goals identified in the ISP. In the event an exception to a service category limit is approved, the combination of services included in the Supports for Community Living Service Category and the Professional and Technical Supports Service Category may not exceed $30,000 per participant per year, unless Emergency Services are approved. However, a waiver participant can exceed this $30,000 cap if the sole reason the limit would be exceeded is a change in the reimbursement methodology that is required under the terms of the Statewide Transition Plan described in Attachment 2. of this waiver in order to achieve compliance with the federal~~

~~HCBS Settings Rule.~~

Supplemental emergency assistance services may be provided in an amount not to exceed $6,000 when: (a) the total cost of services ~~or combination of services included in Supports for Community Living and the Professional and Technical Supports Service Categories~~ totals $360,00~~0~~ and (b) the participant has experienced the following:
- Permanent or temporary involuntary loss of the participant's current residence for any reason;
- Loss of the current caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the individual;
- Significant changes in the behavioral, physical or mental condition of the individual that necessitates increased services.
~~- Emergency Assistance consists of services available in the Supports for Community Living Category and the Professional and Technical Supports Service Category.~~
- In addition, selected services have service limits as specified in Appendix C-1/C-3.
~~- Limits on Sets of Services are discussed in the Family Resource Guide and during a service recipient's original orientation to the Self-Determination Waiver.~~

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.

The maximum individual cost limit is $360,000 per program year per individual. ~~The $30,000 limit provides for up to $23,000 per year per individual in the Supports for Community Living Category, and $7,000 per year per individual in the Professional and Technical Support Services Category. Exceptions may be granted to increase the $23,000 or $7,000 limit so long as the $30,000 combined limit is not exceeded. However, a~~ A waiver participant can exceed this limit if the sole reason the limit would be exceeded is a change in the reimbursement methodology that is required under the terms of the Statewide Transition Plan described in Attachment 2. of this waiver in order to achieve compliance with the federal HCBS Settings Rule.

When an individual's budget reaches $360,000, emergency assistance services may be provided to the person in an amount up to $6,000 (as described above) in order to provide an extra measure of protection when the person experiences a crisis or emergency situation that threatens his/her health and well-being.

The total of all waiver services shall not exceed $42~~36~~,000 per year per participant.

The $360,000 per year per individual limit on all waiver services and hard cap of $42~~36~~,000 per year per individual (inclusive of up to $6,000 in Emergency Services, when necessary) which are uniformly applied to all waiver participants were established with input from consumers, family members, and other stakeholders, as well as review of HCBS utilization in similar programs in other states in order to provide a wide array of services and an adequate level of home and community based services to sustain community living in the most integrated setting appropriate while assuring their health, safety and welfare. ~~The 372 report for year ending 2015 reported an average expenditure of $18,809 per person. Upon approval of this waiver renewal, the projected average expenditure is $21,324 per person for 2018.~~

Subject to applicable service limits~~, limits on sets of services,~~ and cost limits, an individualized budget is established for each waiver participant, based on an individualized assessment of his or her needs, and the specific waiver services that will be needed as specified in the ~~Individual Support Plan~~ PCSP (i.e., plan of care).

~~The methodology for determining the individual budget is detailed in the DIDD Provider Manual and therefore is open for public inspection.~~
The individual budget is defined as the total cost of all waiver services authorized in the ~~Individual Support Plan~~ PCSP.

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

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

In addition to shared residential settings, specific settings to which the HCBS settings rule apply include any settings where the following services are provided: Facility-Based Day Supports, Community Participation Supports,

Supported Employment (Individual and Small Group Employment Support), Intermittent Employment and Community Integration Wrap-Around Supports, and Non-Residential Homebound Support Services.

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

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

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

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

The Interagency Agreement between TennCare and DDA/~~IDD~~ for operation of these waivers includes HCBS Settings Rule compliance, as do Provider Agreements. Each provider is assessed at a minimum, at enrollment, and during the quality assurance survey process to ensure that each service is being delivered to all persons supported in a manner that comports with federal waiver assurances, and the HCBS settings rule. Compliance at the individual member level will continue to be assessed through oversight of the person-centered planning process and review of member experience data. An assessment of each person's experience is embedded into the person-centered planning process on an ongoing basis to ensure that services and supports received by that person are non-institutional in nature, and consistent with the requirements and objectives of the HCBS settings rule. This is conducted by the Independent Support Coordinator, or Case Manager, as applicable, as part of the person's annual person-centered plan review. This assessment is intended to measure each individual's level of awareness of and access to rights provided in the HCBS Settings Rule, freedom to make informed decisions, community integration, privacy requirements, and other individual experience expectations as outlined in the HCBS Settings Rule. DDA/~~IDD~~ reviews assessment responses for all Medicaid recipients receiving services in this waiver and investigates each "No" response that indicates a potential area of non-compliance or potential rights restriction to determine if the provider is in compliance with the HCBS Settings Rule, and with respect to restrictions, to ensure the restriction has gone through the HCBS Settings Rule modifications procedure and is appropriately included in the person-centered support plan. If the restriction has not gone through the modification process and is not supported in the person-centered support plan, DDA/~~IDD~~ remediates the concern by working with the provider and the person supported and his or her representative, if applicable. ~~with providers, TennCare, and DIDD. In addition, HCBS Settings Rule language has been added to the DIDD Provider Manual that sets requirements related to individual rights and modifications to the Rule.~~ DDA/~~IDD~~ will continue to monitor provider compliance with HCBS Settings requirements and will work with ISCs to promptly address remediation of any identified concerns.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

As part of educational materials developed by TennCare and discussed with each waiver participant by his/her ISC as part of the annual person-centered planning process and included in the Member Handbook, each waiver participant will be reminded of his/her right to direct and be actively engaged in the person-centered planning process to the extent desired, and his or her authority to decide who is included in the process.

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

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

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

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

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

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

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

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

~~The Independent Support Coordinator is responsible for providing necessary information and support to the individual to support his/her direction of the person-centered planning process to the maximum extent desired and possible. The~~

Commented [EI4]: DDA Case Manager for Self-Determination Waiver

Commented [EI5]: For Self-Determination Waiver, this will say, "administration of support coordination by DDA, Case Managers are charged with… "

Commented [EI6]: DDA CM for SD waiver

~~person supported has the authority to decide who is included in the development of the PCSP (PCISP).~~

Appendix D: Participant Services

D-1 Service Plan Development (4 of 8)

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

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

~~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 ISPPCSP~~

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

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

Commented [EI7]: Section below revised to better align with the requested sections above and to reflect person-centered updates in support coordination expectations and processes

Commented [EI8]: DDA Case Managers for Self-Determination Waiver

Commented [EI9]: Same as above

- ~~c~~c. Additional assessments, where appropriate, by health care professionals (e.g., occupational or physical therapists, behavior analysts, etc.);~~;~~
- Additional information about participant needs, preferences and goals, and health status are gathered as part of the person-centered planning process, including ~~c~~d. ~~T~~the identification of personal outcomes, ~~support~~ goals, supports and services needed, information about the person's current situation, including health status, what is important to and for the person supported, and changes desired in the person's life (e.g., home, work, relationships, community ~~membership~~ engagement, health and ~~wellness~~ wellness, etc.~~)~~); and ~~(Information for the ISPPCSP will be gathered and developed through the person-centered planning process driven, to the greatest extent possible, by the person supported and, if applicable, in collaboration with the guardian or conservator, as well as family members and other persons specified by the person supported.);~~

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

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

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

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

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

Commented [EI10]: DDA Case Manager for Self-Determination waiver

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

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

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

Services may start while waiting for the signature to be returned to the ISC/Case Manager, whether electronically or by mail. Signatures will include a date reflecting the PCSP meeting date. ISCs will be responsible for the implementation and monitoring of the PCSP (with oversight from DDA(~~DD~~).

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

~~The ISPPCSP is the fundamental tool by which the state ensures the health and welfare of the individuals served under this waiver. As such, it is subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the person's disability and are responsive to the person's needs and preferences. Ongoing monitoring by ISCs is accomplished through a stratified approach, based on level of support need, as follows: A person assessed to have level of need 1, 2, or 3 for purposes of reimbursement or not receiving any residential or day service requires a minimum of at least one monthly in-person or telephone contact and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home. A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires a minimum of at least one monthly face-to-face contact across all environments and in the person's residence at least quarterly. Residential level of reimbursement is the overriding determinant of the contact frequency. Day services level of need will only determine visit frequency if the person receives no residential services. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ISPPCSP for that person per service received across service settings. Face-to-face visits should be coordinated with the person supported (and their family, as applicable) and should generally occur in the person's residence at least once per quarter. However, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home. When an individual receives residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request or based on a significant change in needs or circumstances. The frequency of monitoring visits may be provided more frequently as needed. Information is gathered using standardized processes and tools.~~

Commented [EI11]: DDA CM for SD Waiver

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

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

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

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

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

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

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

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

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

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

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

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

Appendix D: Participant Services

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

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

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

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

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

Appendix D: Participant Services

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

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

The ISC will provide information about selecting from among qualified contracted providers of the waiver services in the ~~ISP~~PCSP.

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~~PCSP and if the services described in the plan are meeting the person's needs.

Commented [EI12]: Everywhere this says ISC would be DDA CM in the SD Waiver

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

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

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

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

Sampling Approach *(check each that applies):*
☐ 100% Review
☑ Less than 100% Review
☐ ☑ Representative Sample Confidence Interval: ~~+/- 5%~~

☑ ☐ Stratified Describe Group: subgroups among the three grand regions in Tennessee (West, Middle, and East)
☐ Other

The State is adding the following new performance measure:

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDA/~~IDD~~ Participant Satisfaction Survey

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

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

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

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

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

Methods for Remediation/Fixing Individual Problems

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

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

Commented [EI13]: DDA CMs for SD waiver

III. Adding consumer direction options for Statewide and CAC Waivers

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services E-1: Overview (1 of 13)

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

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

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

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

Commented [EI14]: Changes are applicable to Statewide and CAC waivers. The language in the SD Waiver remains unchanged.

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

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

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

- Providing the person supported or the guardian/conservator of the person supported with the information and materials required for them to carry out consumer direction
- Preparing and submitting a monthly budget status report to the person supported and the ISC; and
- Verification that providers of services managed by the person supported possess the qualifications specified in state regulations and arranging for the criminal background checks at no cost to the person supported.

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

:

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

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

~~d.~~

Appendix E: Participant Direction of Services E-1: Overview (2 of 13)
b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*: ~~c.~~ The State will select Both Employer and Budget Authority. The budget for each service will be established in accordance with TennCare policy.

~~d.~~c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

Consumer direction will be available only to participants who live in their own private residence or the home of a family member. Only the following services may be consumer directed: personal assistance, respite, and individual transportation services.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

~~e.~~d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

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

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

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

~~g.~~

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

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

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

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

The ISC will verify that a representative meets these qualifications.

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

☐ Governmental entities

X Private entities

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

Appendix E: Participant Direction of Services E-

1: Overview (8 of 13)

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

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

The waiver service entitled:

X FMS are provided as an administrative activity.

Provide the following information

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

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

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

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

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

	Supports furnished when the participant is the employer of direct support workers:
X	Assist participant in verifying support worker citizenship status
X	Collect and process timesheets of support workers

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

X Other

Specify:

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

-Filing claims for waiver services provided through consumer direction;

Supports furnished when the participant exercises budget authority:

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

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

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

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

☐ Other services and supports

Specify:

Additional functions/activities:

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

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

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

☐ Other

Specify:

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

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

DDA~~IDD~~ reports findings of its audits to TennCare via monthly Quality Monitoring Reports.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

required, provide the additional information requested *(check each that applies)*:

X Waiver Service Coverage.

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

~~10.~~ Support Coordination

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

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

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

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

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

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

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

Commented [EI15]: Note that individuals participating in consumer direction may receive assistance through TennCare's contracted Beneficiary Supports System.

Appendix E: Participant Direction of Services E-1: Overview (11 of 13)

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

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

Appendix E: Participant Direction of Services E-1: Overview (12 of 13)

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

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

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

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

3. The person's health, safety, and welfare are in jeopardy if the person or his or her representative continues to employ a worker, but the person or representative does not want to terminate the worker. 4.

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services E-1: Overview (13 of 13)

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

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

YEAR	YEAR	CAC	SW	TOTAL
1	2025	5	67	72
2	2026	6	69	75
3	2027	7	71	78
4	2028	8	73	81
5	2029	9	75	84
TOTAL		35	355	390

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

X Recruit staff

X Hire staff common law employer

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

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

X Determine staff wages and benefits subject to State limits

X Schedule staff

X Orient and instruct staff in duties

X Supervise staff

X Evaluate staff performance

X Verify time worked by staff and approve time sheets

X Discharge staff (common law employer)

Appendix E: Participant Direction of Services

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

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

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

X Determine the amount paid for services within the State's established limits

X Schedule the provision of services

X Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

X Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

Appendix E: Participant Direction of Services

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

Commented [EI16]: These changes apply to SD waiver only

b. Participant - Budget Authority

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

~~The individual budget shall include the cost of services in the Supports for Community Living Service Category and the Professional and Technical Support Services Category. As provided in Appendix B, the amount of the individual budget for the services under the Supports for~~

~~Community Living Category shall not exceed $23,000 unless an exception has been approved. The amount of the individual budget for the services under the Professional and Technical Support Services Category shall not exceed $7,000 unless an exception has been approved.~~

Unless supplemental Emergency Assistance has been authorized, the total amount of the individual budget is subject to a $3~~6~~9,000 per calendar year per waiver participant limitation. In the event that a person's budget has reached $3~~6~~9,000 and the person experiences an emergency or crisis (e.g., a family member can no longer provide the level of support that was previously provided), supplemental Emergency Assistance up to $6,000 may be provided as indicated in Appendix B. The total budget for all waiver services, including Emergency Assistance, shall not exceed $42~~36~~,000 per calendar year per needs of the person supported.

~~The DIDD Provider Manual, discusses both the method by which a person supported is capable of directly managing services and the latitude available within practice as it relates to selection of provider and services. The provider manual and all relevant DIDD protocols are made available to the public via the DIDD web site.~~

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.

Individuals will select their choice of provider from among those contracted with DDA that is willing and available to initiate services timely and to consistently provide services in accordance with the PCSP. The person is not entitled to receive services from a particular provider or to a fair hearing if he is not able to receive services from the provider of his choice.

PROCESS:

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

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

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

Clarifications to the Grievance and Complaint process in Appendix F

Appendix F: Participant Rights

Appendix F-3: State Grievance/Complaint System

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

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

A grievance or complaint may be submitted to the provider, DDA~~IDD~~, or TennCare.

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

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

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

DDA~~IDD~~ Complaint Resolution System

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

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

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

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

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

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

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

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

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

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

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

DIDD Complaint Resolution System

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

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

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

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

Information collected is compiled and reported to TennCare in the monthly Quality Management Report, and data files, which are available to TennCare upon request, are also completed by DDA/DD Complaint Resolution Customer-Focused Services Staff for each complaint with data detailing the number and type of complaints

received, referral sources, remedial actions, and timeframes for achieving resolution.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

The DDA~~IDD~~ ~~Protection From Harm~~ Reportable Event Management Unit receives Tier 1 allegations of abuse, neglect, exploitation, serious injuries of unknown cause and suspicious deaths. All such ~~incidents~~ events are investigated by trained DDA~~IDD~~ investigators who interview the participant, service provider, and all available witnesses. The DDA~~IDD~~ investigators examine the ~~incident~~ event scene and collect other available relevant circumstantial evidence (written statements, expert medical opinions as needed, etc.). Based on the ~~preponderance of the cited~~ evidence obtained, a preponderance of evidence determines if an allegation is determined to meet a Class II substantiation. Clear and convincing evidence is the standard that must be met to support a Class I substantiation, at which time the DDA Office of Administrative Appeals (OAA) process is initiated. E~~e~~ach 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 assigned as an investigation ~~witnessed or discovered~~. In some extraordinary situations, such as a pending criminal investigation, the DDA~~IDD~~ investigation may take longer than 30 calendar days. DDA~~IDD~~ requires the waiver service provider to develop and implement a written ~~management~~ action plan that addresses the issues and conclusions specified in the substantiated DDA~~IDD~~ Investigation~~s~~ report within 10~~4~~ calendar days of the completion of the Investigation Report.

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

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

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

Service providers are responsible for conducting investigations of Tier 2 Reportable Events and submitting an investigation report to DDA~~IDD~~ for each Tier 2 allegation. A completed investigation report and attachments shall be submitted to DDA~~IDD~~ within twenty-five (25) calendar days of the date the provider receives notification of the investigation assignment/opening. DDA is responsible for the review of both the final report and all relevant evidence prior to approval and closure of the Tier 2 Investigation completed by the service provider.

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 Disability and Aging ~~Intellectual and Developmental Disabilities~~ (DDA~~IDD~~) is the agency responsible for overseeing the reporting of and response to all "Reportable ~~Incidents~~Events".
All "Reportable ~~Incidents~~Events" received by DDA~~IDD~~ are reviewed for completeness of information (with follow-up for more information if needed), are categorized according to written criteria, and are entered into an electronic database. This database provides data management capabilities including the ability to:

~~1.~~ Generate "alerts" of individual ~~incidents~~ events to designated DDA~~IDD~~ staff for follow-up as needed;
~~2.~~ Support reporting to external entities (e.g., TennCare); and
~~3.~~ Support internal DDA~~IDD~~ trends analysis and reporting functions such as:
~~a.~~ Identification of at-risk participants;
~~b.~~ Identification of employees or contract staff with multiple episodes of substantiated abuse, neglect, and exploitation allowing voluntary screening of prospective employees by service providers during the hiring process;
~~c.~~ Identification of at-risk situations (e.g., data on injuries from falls);
~~d.~~ Creating a detailed profile of identified service providers, with information about reportable ~~incidents~~ events related to that provider, and for comparison between service providers; and
~~e.~~ Distribution of monthly reports to DDA~~IDD~~ management and other staff.
All ~~Incident~~ Reportable Event and Investigation reports completed by DDA~~IDD~~ are available for TennCare review. Monthly data files and Quality Management Reports are submitted to TennCare containing information about the number and types of ~~critical incidents~~ reportable events reported, the number of investigations initiated and completed, the number and percentage of substantiated allegations, and time frames for completion of investigations. TennCare reviews ~~incident~~ reportable event and investigation data to ensure appropriate and timely remediation of identified findings. TennCare notifies DDA~~IDD~~, on a monthly basis, of any investigation findings that are not acceptably remediated. DDA~~IDD~~ is required to provide additional information and/or take additional remedial action until TennCare can determine that appropriate remediation has taken place.

- Slight adjustments in Appendix G pertaining to restraints

Appendix G: Participant Safeguards

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

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

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

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

Staff are required to use positive proactive and reactive strategies for preventing and minimizing the intensity and risk factors presented by an individual's behavior whenever possible in order to minimize the use of ~~personal and mechanic~~al behavior-related restraints. Interventions that should be employed prior to the use of restraints must be documented in the ~~person-centered ISP~~PCSP. Staff must be trained on the use of positive interventions and document that positive interventions were employed prior to the use of restraints. Emergency ~~personal restraint, mechanical restraint~~ behavior-related restraints, or emergency medication (chemical restraint) ~~is~~ are used only as a last resort to protect the person or others from harm. The use of emergency ~~personal restraints or mechanical~~ restraints requires proper authorization, is limited to the time

period during which it is absolutely necessary to protect the individual or others, and is not permitted as a punishment by staff, for staff convenience, or in lieu of person-centered programmatic services. The provider agency director or designee must ensure that staff are able to correctly apply the emergency ~~personal restraint or mechanical~~ restraint.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

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

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

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of

residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Medication Management and Follow-Up

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

DDA~~IDD~~ Regional Office staff receive and review reportable ~~incident~~ event forms for completeness and determination of the nature of the ~~incident~~event. DDA~~IDD~~ monitors for medication variance trends utilizing data from the ~~Incident~~ Reportable Event and Investigations database.
If a person supported is using a behavior modifying medication (including psychotropic medications, the DDA~~IDD~~ Regional Quality Assurance surveyors will determine whether (1) there is documentation of voluntary, informed consent for the use of the medication; (2) the persons supported or the person's family member or guardian/conservator was provided information about the risks and benefits of the medication; and (3) the use of a behavior modifying medication as a restricted intervention was reviewed by the Circle of Support, the provider reportable event review team, Behavior Support and/or Human Rights Committees, as required.

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

DDA~~IDD~~, in conjunction with the MCOs, is responsible for oversight of medication management.

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a.i.2. # and % of participant satisfaction survey respondents who indicated knowledge of how to report a complaint. (DDA~~IDD~~ People Talking to People Consumer Survey question: Do you know how to report a complaint?). Percentage = survey respondents able to relate how to appropriately report a complaint / number of waiver participants in the sample who responded to this survey question.

a.i.3. # and % of participant satisfaction survey respondents who reported being treated well by direct support staff. (DDA~~IDD~~ People Talking to People Survey question: Do your support staff treat you well or with respect?) % = # of survey respondents who reported being treated well by direct support staff / total # of waiver participants in the sample who responded to this survey question.

a.i.4. Number and percentage of participant satisfaction survey respondents who reported having sufficient privacy. (DDA~~IDD~~ People Talking to People Survey question: Are you satisfied with the amount of privacy you have?) Percentage = survey respondents reporting sufficient privacy / total waiver participants in the sample who responded to this participant satisfaction survey question.

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

The State is adding the following new performance measure:

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDA~~IDD~~ Participant Satisfaction Survey

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

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

The State is revising the following performance measure:

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

The State is revising the data source for the following performance measures:

a.i.20 Number and percentage of DDA~~IDD~~ providers surveyed who demonstrate regular review of their reportable events.= # and % of DDA~~IDD~~ providers surveyed who demonstrate regular review of their reportable events / Total DDA~~IDD~~ providers surveyed.

a.i.21 Number and percentage of DDA~~IDD~~ providers surveyed who demonstrate they are implementing preventive/corrective strategies when applicable. # and % of DDA~~IDD~~ providers surveyed who demonstrate they are implementing preventive/corrective strategies when applicable / total DDA~~IDD~~ providers surveyed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

~~DIDD Quality Assurance Surveys~~ DDA Qualified Provider Reviews

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

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

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

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

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

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

Performance Measures a.i.~~22~~ 20 and a.i.~~25~~ 21 are reviewed during DDA~~IDD~~ ~~Quality Assurance (QA) Surveys~~ Qualified Provider Reviews.

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

Performance Measures a.i.2, a.i.3, ~~and~~ a.i.4, and a.i.26: When individuals do not know how to report complaints and/or abuse, neglect, or exploitation, the satisfaction survey interviewer will provide the appropriate information. The DDA~~IDD~~ People Talking to People Director or designee will contact the waiver participant and/or person assisting the waiver participant who received complaint and/or abuse, neglect, and exploitation reporting instruction within 60 days to verify that the person who received information knows how to report complaints and/or abuse, neglect, and exploitation and has the appropriate written resources describing reporting processes. On a monthly basis, the DDA~~IDD~~ People Talking to People Director will report

information regarding the number of survey respondents who did not know how to appropriately report a complaint and/or abuse, neglect, or exploitation, as well as education provided and verifications completed, to DDA~~IDD~~ Central Office staff responsible for data aggregation.

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability language will be modified as follows as it relates to Fiscal Accountability Reviews of providers:

Policy defines applicable providers as those with annual billing ~~in excess~~ of $500,000 and up.

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

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

~~Proposed service rates are determined by the Department of Intellectual and Developmental Disabilities (DIDD) and are reviewed and approved by TennCare, the State Medicaid Agency, which has oversight of the rate determination process. TennCare keys approved rates into the MMIS sends approved rates to contracted MCOs for purposes of processing claims for waiver services. The methodology used to determine rates is outlined in Chapter 0465-01-02 of DIDD's Administrative Rules and can be found at this link: https://publications.tnsosfiles.com/rules/0465/0465-01/0465-01-02.20200105.pdf http://publications.tnsosfiles.com/rules/0465/0465-01/0465-01-02.20140312.pdf~~

~~Maximum allowable rates are established for each service based on an analysis of provider costs to deliver services and based on experience, as set forth in DIDD Administrative Rule. The rates for this waiver were restructured in 2005 with the average expenses incurred by providers in 2004 used as the cost model. DIDD continues to make adjustments to the 2005 rates, particularly the direct support professional hourly wage component within the rates, based on feedback from providers and current employment trends.~~

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

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

~~which includes public notice and a rule-making hearing~~.

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

Commented [EI17]: This language currently in Statewide Waiver and being added to CAC Waiver to replace the following: *"to assist waiver participant to obtain and retain competitive integrated employment where hours worked are substantially higher than the average for all waiver participants"*

Appendix I: Financial Accountability

Appendix I Financial Accountability, I-3(g)ii, will be modified to reflect that, "The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10."

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

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

The State is adding the following components under the Supported Employment Individual – Exploration service:

Supported Employment Individual - Exploration

Component Name
Exploration for Individualized Integrated Employment
Exploration for Self-Employment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

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

Service Title:

Support Coordination

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

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

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

□ Service is not included in the approved waiver.

Service Definition (Scope):

Character Count = 12,000

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

Specific tasks performed by the Support Coordination provider shall include, but are not limited to general education about the waiver program and services, including individual rights and responsibilities; providing necessary information and support to the individual to support his/her direction of the person-centered planning process to the maximum extent desired and possible; initial and ongoing assessment of the individual's strengths, ~~and~~ needs and preferences, including an understanding of what is important to and important for the person supported and the development of a PCSP that effectively communicates that information to those providing supports; identification and articulation

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

Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ~~ISP~~PCSP for that person per service received across service settings. In addition to general assurance of health and safety, the purpose of this review shall be to ensure that services and supports are being provided in accordance with the PCSP and are appropriate to support the achievement of individualized goals and

outcomes. Progress toward goals and outcomes shall be reported as part of the Monthly Status Review.

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

Provider Specifications:

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

Provider Specifications:

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

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 Employment – Benefits Counseling

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

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

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

☐ Service is not included in the approved waiver.

Service Definition (Scope):

~~This service is provided by a certified Community Work Incentives Coordinator (CWIC) or certified Work Incentive Practitioner (WIP-C).~~

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:

Enabling Technology

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

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

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

□ Service is not included in the approved waiver.

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

1. 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.
2. 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.
3. 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 Disability and Aging ~~Intellectual and Developmental Disabilities~~ (DDA~~IDD~~).
4. 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~~ National Sexual Offender Registry.
5. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
6. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

~~This service is provided by a certified Community Work Incentives Coordinator (CWIC) or certified Work Incentive Practitioner (WIP-C).~~ Providers must be certified to provide Benefits Counseling as required in TennCare protocol.

Provider Specifications:

Provider Category:
Agency

Provider Type:

Enabling Technology Vendor
Waiver Service Agency

Provider Qualifications

License *(specify):*

~~Provider agencies that have attained 'Technology First Accreditation' with a documented 2 year history of successfully employing person-centered Enabling Technology options to support people at home, their communities and/or at work.~~