Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Amendment 7

Program Enhancements

DRAFT

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Amendment 7 to the TennCare III Demonstration

Since 1994, Tennessee has operated its Medicaid program under the authority of an 1115 demonstration known as TennCare. TennCare is a comprehensive Medicaid reform project, consisting of innovations in multiple aspects of Medicaid, including eligibility, benefits, and service delivery systems. Tennessee currently provides Medicaid coverage to approximately 1.4 million Tennesseans under the authority of the TennCare demonstration.

In this amendment, Tennessee is proposing several changes to the demonstration that will enhance benefits, promote access to care, improve quality outcomes, and improve transparency and program administration. These changes include covering the full continuum of care for individuals with serious mental illness (SMI) and serious emotional disturbance (SED), implementing a new access/quality improvement program for hospitals, and improving the home- and community-based services (HCBS) authorized under the demonstration.

I. Description of the Amendment

This proposed amendment consists of three primary components:

1. Covering the full continuum of care for individuals with serious mental illness (SMI) and serious emotional disturbance (SED);
2. Implementing an access/quality improvement program for hospitals; and
3. Improving home- and community-based services (HCBS) authorized under the demonstration.

Each of these proposals is described below.

Covering the Full Continuum of Care for individuals with SMI and SED

In this demonstration amendment, Tennessee is proposing to amend the benefits package authorized under the demonstration to allow the state to cover the full continuum of care for individuals with serious mental illness (SMI) and serious emotional disturbance (SED). Specifically, Tennessee is requesting expenditure authority to cover services provided to individuals with SMI or SED who are receiving treatment in facilities that meet the federal definition of an institution for mental diseases (IMD).[1] The state's objective in seeking this expenditure authority is to maintain beneficiary access to mental health treatment services in appropriate settings and to ensure that individuals receive care in the settings most appropriate to their needs.

Federal policy generally does not allow Medicaid to cover services for adults under age 65 with SMI or children with SED who are receiving care in a facility that meets the definition of an IMD. Historically, TennCare has not suspended coverage for persons with SMI or SED residing in IMDs; instead, TennCare

[1] IMDs are inpatient facilities with more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. See Section 1905(i) of the Social Security Act.

paid for care provided on behalf of these individuals with state dollars (since federal Medicaid dollars are not available).

The 21st Century Cures Act directed CMS to use its authority under Section 1115 of the Social Security Act to make demonstration opportunities available to states who wish to cover services for persons with SMI or SED residing in IMDs under their Medicaid programs. CMS subsequently issued guidance inviting states to apply for demonstration authority to cover these services.[2] In this demonstration amendment, Tennessee proposes to add services for individuals with SMI/SED residing in IMDs to the TennCare demonstration as covered services. Specifically, Tennessee requests expenditure authority under Section 1115(a)(2) of the Social Security Act to cover medically necessary services furnished to individuals under age 65 residing in facilities that meet the definition of IMD. Although this request will represent a change in the benefits authorized under the TennCare demonstration, this will not result in any change to benefits actually received by individuals enrolled in TennCare (since as noted above, TennCare has historically covered these services for impacted beneficiaries with non-federal dollars).

In requesting this expenditure authority, Tennessee affirms its commitment to achieving various milestones during the course of the demonstration, consistent with any applicable CMS guidance. These include:

- Ensuring quality of care in psychiatric hospitals and residential settings,
- Improving care coordination and transitions to community-based care,
- Increasing access to a continuum of care, including crisis stabilization services, and
- Early identification and engagement in treatment, including through increased integration.

Tennessee already covers a broad array of mental health and substance use disorder treatment services for all individuals enrolled in TennCare, including a wide range of inpatient, residential, outpatient, health home, crisis stabilization, and other supportive services. These services (including services for persons with IMDs paid with state dollars) are fully integrated with each member's physical health care via TennCare's comprehensive managed care program. This expenditure authority will ensure equitable cost sharing between the state and federal government for the costs of care for Medicaid beneficiaries and ensure that TennCare is able to continue providing a full continuum of care for persons with SMI/SED.

Implementing an Access/Quality Improvement Program for Hospitals

In this amendment, Tennessee is also requesting changes to support the implementation of an initiative to ensure access to hospital services for Medicaid beneficiaries in Tennessee and improve the outcomes associated with hospital services provided to Medicaid beneficiaries. Hospital services are included within the managed care program authorized under the TennCare demonstration. In order to maintain and enhance access to hospital care for Medicaid beneficiaries in Tennessee, the state is partnering with hospitals in Tennessee to implement an access and quality improvement initiative. A key component of this initiative will be additional payments to hospitals that achieve agreed-upon quality performance

[2] See State Medicaid Director Letter #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance" (November 13, 2018).

benchmarks. These additional payments to hospitals will be made consistent with 42 CFR § 438.6(c) (concerning state-directed payments, or SDPs, in managed care). Concurrent with this demonstration amendment application, the Managed Care Group (MCG) at CMS is also in the process of reviewing a corresponding SDP application from the state. While MCG will determine whether the state's SDP application meets federal standards governing SDPs, in order to support implementation of this initiative, the state is requesting that the budget neutrality expenditure limit for the demonstration be adjusted to accommodate these additional hospital payments. The state anticipates that these payments will result in an increase in annual aggregate expenditures under the demonstration of $2.5 billion. The state anticipates that, over time, this payment arrangement will support the financial sustainability of hospitals that serve large proportions of Medicaid-covered individuals. This will in turn ensure a sufficient number of hospitals engage in each managed care plan's network to provide timely access to services. Over the longer term, it is also anticipated that these payments will support provider efforts to improve performance, resulting in higher quality services provided to Medicaid managed care enrollees.

HCBS Improvements

The TennCare demonstration currently authorizes three programs of long-term services and supports (LTSS).

- **CHOICES** provides LTSS—including nursing facility services and HCBS—to seniors and to adults with physical disabilities.
- **Employment and Community First CHOICES** (or "ECF CHOICES") provides HCBS to individuals with intellectual or developmental disabilities.
- The **Katie Beckett/Medicaid Diversion** program provides supports to children with disabilities or other complex medical needs.

The oldest of these programs (CHOICES) dates back to 2010, and in this amendment, the state is proposing a number of changes to modernize and update the special terms and conditions (STCs) governing these programs. These changes are intended to improve the efficiency, transparency, and member experience of individuals served by these programs. In addition, the state is proposing a number of changes to enhance the HCBS available to individuals enrolled in these programs and to provide for greater flexibility in the use of HCBS benefits.

Notably, the state's proposed changes include:

1. Providing more flexibility in the use of minor home modifications by eliminating the per project limit on these modifications. This change recognizes the rising costs of building materials and will help ensure that this service continues to meet members' needs.
2. Allowing exceptions to the applicable expenditure cap for persons in ECF CHOICES Group 6 with exceptional medical or behavioral needs so that such individuals may access supported employment services. This change will help ensure that members in ECF CHOICES Group 6 do not face an unnecessary barrier to accessing supported employment services.
3. Revising the definition of Benefits Counseling for CHOICES and ECF CHOICES. The current Benefits Counseling service in CHOICES and ECF CHOICES is reimbursed on an hourly basis and limited

based on hours and years. The state is proposing to combine all limit categories, creating a new payment structure that limits the service to 60 hours per year across all programs.

4. Adjusting the limit on Exploration in ECF CHOICES from 30 days to 60 days. This change will align the limit on Exploration services in ECF CHOICES with that in CHOICES, and will provide for greater flexibility in the use of this service.
5. Adding a definition for the Stabilization and Monitoring service in CHOICES and ECF CHOICES.
6. Removing Rideshare/Community Transportation pre-authorization language for Employment and Day Supports in CHOICES.
7. Updating language about the publishing of enrollment targets in CHOICES and ECF CHOICES to provide greater transparency.
8. Updating outmoded language about transitions from CHOICES and 1915(c) waivers to ECF CHOICES.
9. Removing unnecessary language that interferes with the state's ability to enroll people in ECF CHOICES Group 6.
10. Clarifying the data reporting requirements for ECF CHOICES and the Katie Beckett/Medicaid Diversion program to provide maximum transparency around both of these programs.

The state's specific proposed STC edits are illustrated in Attachment A.

II. Proposed Waiver and Expenditure Authorities

All waiver and expenditure authorities currently approved for the TennCare demonstration will continue to be in effect.

To effectuate the changes described in this amendment for individuals with SMI/SED, the state requests expenditure authority under Section 1115(a)(2) of the Social Security Act to cover medically necessary services furnished to individuals with SMI/SED under age 65 enrolled in TennCare who are receiving treatment in a facility that meets the definition of an IMD.

The state is not proposing any new waiver or expenditure authorities to implement a hospital access/quality improvement program. Rather, the state is seeking an adjustment to the demonstration's expenditures and budget neutrality framework.

The state is not proposing any new waiver or expenditure authorities to effectuate the changes related to the demonstration's HCBS programs described in this amendment. These modifications will involve changes and clarifications to the demonstration's existing special terms and conditions. (See Attachment A.)

III. Expected Impact on Enrollment and Budget Neutrality

Implementation of this amendment is not expected to result in changes to TennCare enrollment.

The state's request to cover services for individuals with SMI/SED residing in IMDs is expected to result in an increase of approximately $25 million in annual aggregate expenditures under the demonstration, representing approximately 1,800 member months per year.

The state's request to implement a hospital access/quality improvement program is expected to result in an increase of $2.5 billion in annual aggregate expenditures under the demonstration.

The enhancements to the demonstration's HCBS programs described in this amendment are not expected to result in material changes to aggregate expenditures under the demonstration.

Attached is an updated overview of the demonstration's finances that reflects these adjustments.

IV. Expected Impact on CHIP Allotment Neutrality

This amendment will not result in any changes to Tennessee's CHIP allotment neutrality.

V. Updates to Monitoring and Evaluation Processes

The anticipated impacts of this amendment on the monitoring and evaluation processes for the TennCare demonstration are described below.

Covering the Full Continuum of Care for individuals with SMI and SED

Tennessee is committed to appropriate monitoring and evaluation of the requested demonstration authorities and will work with CMS to develop appropriate tools to guide the monitoring and evaluation processes associated with its coverage of services for persons receiving care for SMI/SED in IMDs.

In developing the monitoring, evaluation, and reporting structures for these authorities, it is expected that the monitoring metrics agreed to by the state and CMS will be informed by and adhere closely to the monitoring metrics recommended by CMS for SMI/SED demonstrations.[3] Likewise, Tennessee will work with CMS to modify the TennCare evaluation design to address these new authorities in a manner consistent with CMS guidance related to the evaluation of SMI/SED demonstrations.[4]

In working with CMS to modify the evaluation design for the TennCare demonstration, the hypotheses and research questions will reflect that the proposed expenditure authority does not reflect an actual change in the benefits available to individuals enrolled in TennCare, merely to the availability of federal Medicaid funds to support these benefits.

[3] See https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html

[4] Ibid.

Implementing an Access/Quality Improvement Program for Hospitals

With regard to the hospital access/quality improvement program, the state will work with the managed care group at CMS to identify appropriate evaluation metrics for the state-directed payment that will support the program, and will work with the state demonstrations group at CMS to ensure that those metrics are incorporated into the evaluation design.

HCBS Improvements

The state does not anticipate modifying its evaluation design based on the proposed changes to the demonstration's HCBS programs. These changes are expected to contribute to key goals of the TennCare demonstration already reflected in the demonstration's evaluation design (currently under CMS review). These include enhancing coverage and benefits available under the TennCare demonstration and supporting access to safe and appropriate HCBS.

VI. Demonstration of Public Notice and Input

The state has used multiple mechanisms for notifying the public about this amendment and for soliciting public input on the amendment. These public notice and input procedures are informed by—and comply with—the requirements specified in STC 12 of the TennCare demonstration and 59 Fed. Reg. 49249.

Public Notice

The state held a formal notice and comment period on this proposed demonstration amendment from September 12, 2024, through October 11, 2024. During this time, a comprehensive description of the amendment to be submitted to CMS was available for public review and comment on an amendment-specific webpage on the TennCare website. In addition, a notice of the state's intent to submit a demonstration amendment was published in newspapers of general circulation in Tennessee communities with 50,000 or more residents. This newspaper notice described the major elements of the proposed amendment and provided instructions for how to access the full proposal on the TennCare website. The newspaper notice also provided instructions for submitting comments on the proposed amendment to the state during the notice and comment period. In addition, the state notified the public of its intent to submit a demonstration amendment via social media (i.e., Facebook, Twitter) with links to the comprehensive notice on the state's website. The state made copies of its notice available in county health departments throughout the state. TennCare also notified the members of the Tennessee General Assembly of this amendment via an electronically transmitted letter.

Attachment A
Proposed CHOICES, ECF CHOICES and Katie Beckett/Medicaid Diversion STC Edits

V. BENEFITS

29. TennCare Benefits.

i. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES demonstration eligibles who are enrolled in the designated CHOICES groups (specified in STC 33.a, *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

Table 2b: Benefits for Persons Enrolled in the CHOICES Program			
Benefit (Definitions provided in Attachment E)	**CHOICES 1**	**CHOICES 2**	**CHOICES 3**
Minor home modifications (up to ~~$6,000 per project;~~ $10,000 per calendar year~~;~~ and $20,000 per lifetime)		X	X

j. The following tables (Tables 2c and 2d) list the HCBS benefits (and limits on those benefits) for TennCare Medicaid enrollees and demonstration eligibles who are enrolled in the ECF CHOICES benefit groups (specified in STC 34.a. *Determination of ECF CHOICES Benefits by Designation into an ECF CHOICES Benefit Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the ECF CHOICES benefits.

iv. ECF CHOICES benefits will be subject to an annual per member expenditure cap as follows. The cost of medical assistance provided to an eligible participant in ECF CHOICES, including any exceptions to the expenditure cap granted under this STC, is limited to the amount calculated in the individual cost-neutrality test used in Section 1915(c) waivers as set forth in Section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs.

C. Individuals receiving Comprehensive Supports for Employment and Community Living benefits will be subject to an annual expenditure cap as follows:

4. The state may grant exceptions to these expenditure caps on a case-by-case basis as follows:

b. For an individual with low, moderate, or high need (~~but not~~ <u>including</u> exceptional medical or behavioral needs), an exception may be made to the applicable expenditure cap when necessary to permit access to Supported Employment and/or Individual Employment Support benefits. The amount will be determined per individual based on the individual's need.

Table 2d **Benefits and Benefit Limits in ECF CHOICES Benefit Groups**

Benefit (Definitions provided in Attachment H)	**Essential Family Supports**	**Essential Supports for Employment and Independent Living**	**Comprehensive Supports for Employment and Community Living**	**Intensive Behavioral Family Supports**	**Comprehensive Behavioral Supports for Employment and Community Living**
Minor home modifications (up to ~~$6,000 per project;~~ $10,000 per calendar year~~;~~ and $20,000 per lifetime)	X	X	X	X	X

k. The following table (Table 2e) lists benefits for the Katie Beckett eligibility group (specified in STC 23.a. *Katie Beckett (Part A)*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition to the service limits stated in Table 2e, the total cost of the HCBS identified in Table 2e shall not exceed $15,000 per calendar year.

Table 2e **Benefits and Benefit Limitations Katie Beckett (Part A) Eligibility Group**	
Benefit	**Amount Duration and Scope**
Minor home modifications	Up to ~~$6,000 per project;~~ $10,000 per calendar year~~;~~ and $20,000 per lifetime

l. The following table (Table 2f) lists benefits for the Medicaid Diversion (Part B) eligibility group (specified in STC 24). In addition to the service limits stated in Table 2f, the total cost of the services and supports identified in Table 2f shall not exceed $10,000 per calendar year.

Table 2f **Benefits and Benefit Limitations Medicaid Diversion (Part B) Eligibility Group**	
Benefit	**Amount Duration and Scope**
Minor home modifications	Up to ~~$6,000 per project;~~ $10,000 per calendar year~~;~~ and $20,000 per lifetime

VI. CHOICES, ECF CHOICES, KATIE BECKETT, AND MEDICAID DIVERSION ENROLLMENT

33. Operations of the TennCare CHOICES Programs.

d. Enrollment Targets for TennCare CHOICES. The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal

resources. Information on CHOICES Groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Monitoring Report as set forth in STCs 55 *(Monitoring Reports),* 56 *(Enrollment Report)*.

i. The CHOICES targets will include both upper limits and lower limits, with the actual target number to be published ~~in state rules~~ by the state. The upper limit will serve as a ceiling on the enrollment target; TennCare will not set the target above the upper limit. The lower limit will serve as an enrollment floor; TennCare will not set the target below the lower limit. To help ensure continuity of eligibility and benefits, the target for each benefit group will not be less than enrollment in that group at the time the target is established.

34. Operations of Employment and Community First (ECF) CHOICES

c. **Enrollment in ECF CHOICES.** The effective date of enrollment in ECF CHOICES shall be established by the state based on a determination that an applicant is eligible for and will begin receiving LTSS. To be eligible for ECF CHOICES, individuals must be determined by TennCare to meet all applicable eligibility and enrollment criteria.

i. For enrollment in Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6) or Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES Group 8), the state may grant an exception to individuals transitioning either from the Statewide or Comprehensive Aggregate Cap Waivers or from an ICF/IID who are "at risk" of institutionalization and meet the ICF/IID but not the NF LOC.

ii. Individuals enrolled in a Section 1915(c) waiver shall ~~not~~ only be permitted to transition into ECF CHOICES~~, even if they meet the criteria for ECF CHOICES eligibility, until such time that the state determines that such transitions can be permitted~~ when it is determined they meet all enrollment criteria, and it is further determined that their needs can no longer be safely and appropriately met within the cost neutrality of the 1915(c) waiver in which they are currently enrolled and in accordance with timeframes and procedures established by the state.

iii. Individuals enrolled in CHOICES Group 2 or 3 shall ~~not~~ only be permitted to transition into ECF CHOICES~~, even if they meet the criteria for ECF CHOICES eligibility, unless~~ when the state determines that the individual qualifies for ECF CHOICES, the individual's needs can be more appropriately met in ECF CHOICES, and in accordance with timeframes and procedures established by the State.

d. Enrollment Targets for ECF CHOICES. The state may establish enrollment targets for ECF CHOICES. The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on ECF CHOICES groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Monitoring Report as set forth in STCs 55 *(Monitoring Reports),* 56 *(Enrollment Report)*.

i. The ECF CHOICES targets will include both upper limits and lower limits, with the actual target number to be published ~~in state rules~~ by the state. The upper limit will serve as a ceiling on the enrollment target; TennCare will not set the target above the upper limit. The lower limit will serve as an enrollment floor; TennCare will not set the target below the lower limit. To help ensure continuity of eligibility and benefits, the target for each benefit group will not be less than enrollment in that group at the time the target is established. ~~Persons transitioning into ECF CHOICES from a Section 1915(c) waiver or from CHOICES Groups 2 or 3 shall not count against the enrollment target for the ECF CHOICES Group in which they are enrolled.~~

ii. The state will submit to CMS at least 60 days prior to the implementation of ECF CHOICES and at least 60 days prior to the beginning of each program year a proposed enrollment target range for each benefit group. The state may, during the course of each year, adjust the specific enrollment target for each group so long as the target remains within the approved enrollment target range for that benefit group and the state provides notification to CMS at least 30 days prior to the desired effective date of the change. Except as specified in STC 34.d.iv, an amendment is required for any proposed adjustment in the enrollment target outside the approved range.

~~iii. Any enrollment target for Essential Supports for Employment and Independent Living will be at least twice as high as any enrollment target for Comprehensive Supports for Employment and Community Living.~~

iv. If the enrollment target established by the state for ECF CHOICES is reached or exceeded, the state shall not enroll additional persons in ECF CHOICES, except as provided below. The state may also establish a waiting list, subject to the following:

A. Reserve Capacity. The state may reserve slots in ECF CHOICES for individuals being discharged from a NF or an ICF/IID, and for individuals being discharged from an acute care setting who are in imminent risk of being placed in an NF or ICF/IID setting, absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Monitoring Report. The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 days advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Monitoring Reports must reflect any such changes. In each Quarterly Monitoring Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for ECF CHOICES, the number enrolled in each ECF CHOICES group, and the numbers of slots being held in reserve for various purposes.

B. HCBS as a Cost-Effective Alternative. An MCO with a TennCare enrollee who meets the criteria for ECF CHOICES, but which cannot enroll the individual in ECF CHOICES because the enrollment target has been met, has the option, at

its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care. Such an enrollee would be served in ECF CHOICES outside the applicable enrollment target but moved within the applicable enrollment target at such a time as a slot becomes available. The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of provider capacity to meet the member's needs prior to enrollment in ECF CHOICES.

C. Exception to Enrollment Targets for ECF CHOICES 4 and 6 for Transitions from ECF CHOICES 7 or 8. An enrollee being served in ECF CHOICES 7 or 8 who meets the requirements to enroll in ECF CHOICES 4 or 6 may enroll in ECF CHOICES 4 or 6 at any time such a transition can be accomplished, even if an enrollment target for ECF CHOICES 4 or 6 has been reached. Such an enrollee would be served in ECF CHOICES 4 or 6 outside the applicable enrollment target but moved within the applicable enrollment target at such a time as a slot becomes available.

D. Persons Transitioning into ECF CHOICES from a Section 1915(c) Waiver or from CHOICES Groups 2 or 3. An enrollee being served in CHOICES Group 2 or 3 or a 1915(c) waiver who meets the requirements to enroll in ECF CHOICES may enroll in ECF CHOICES at any time such a transition can be accomplished, even if the ECF CHOICES Group enrollment target has been reached. Such an enrollee would be served in ECF CHOICES outside the applicable enrollment target but moved within the applicable enrollment target at such a time as a slot becomes available.

IX. GENERAL REPORTING REQUIREMENTS

52. CHOICES, ECF CHOICES, and Katie Beckett (Part A) Data.

b. ECF CHOICES ~~and Katie Beckett~~ Data Plan. The state will collect and submit data to CMS, including the following data elements. "Point in time" refers to June 30 of each year.

i. Number of persons with ID actively receiving HCBS upon implementation and at a point in time. Data shall be reported for across Medicaid HCBS programs (including Section 1915(c) waivers).

ii. Number of persons with DD (other than ID) actively receiving HCBS upon implementation and at a point in time. Data shall be reported only for ECF CHOICES ~~and Katie Beckett (Part A)~~;

iii. Number of persons with I/DD actively receiving HCBS upon implementation and at a point in time. Data shall be reported across Medicaid HCBS programs (including Section 1915(c) waivers);

iv. Unduplicated number of persons with ID actively receiving HCBS during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported across Medicaid HCBS programs (including Section 1915(c) waivers);

v. Unduplicated number of persons with DD (other than ID) actively receiving HCBS during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported only for ECF CHOICES ~~and Katie Beckett (Part A)~~;

vi. Unduplicated numbers of persons with I/DD receiving HCBS during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported across Medicaid HCBS programs (including Section 1915(c) waivers);

vii. Average per person LTSS expenditures for individuals with I/DD during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported for ECF CHOICES, ~~Katie Beckett (Part A),~~ ICF/IID services, and across Medicaid HCBS programs (including Section 1915(c) waivers);

viii. Total HCBS expenditures for individuals with I/DD during a 12 month period prior to implementation and each demonstration year thereafter, including as a percentage of total LTSS expenditures for individuals with I/DD;

ix. Number of persons with I/DD employed in an integrated setting at or above the minimum wage upon implementation of ECF CHOICES and at a point in time. Data shall be reported for ECF CHOICES and across Medicaid HCBS programs (including Section 1915(c) waivers);

x. Percentage of persons with I/DD reporting improved quality of life as measured by a standardized instrument.

c. Katie Beckett (Part A) and Medicaid Diversion (Part B) Data Plan. The state will collect and submit data to CMS, including the following data elements. "Point in time" refers to June 30 of each year.

i. Number of persons actively receiving HCBS upon implementation and at a point in time. Data shall be reported for Katie Beckett (Part A) and Medicaid Diversion (Part B) separately;

ii. Unduplicated number of persons actively receiving HCBS during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported for Katie Beckett (Part A) and Medicaid Diversion (Part B) separately;

iii. Number of persons enrolled in Katie Beckett (Part A) (point in time);

iv. Unduplicated number of persons enrolled in Katie Beckett (Part A) during a 12 month period prior to implementation and each demonstration year thereafter;

v. Average per person TennCare expenditures for individuals enrolled in Katie Beckett (Part A) during a 12 month period prior to implementation and each demonstration year thereafter;

vi. Total HCBS expenditures for individuals during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported for Katie Beckett (Part A) and Medicaid Diversion (Part B) separately;

vii. Percentage of Katie Beckett (Part A) and Medicaid Diversion (Part B) members reporting improved quality of life as measured by a standardized instrument.

Attachment E
Glossary of Terms for TennCare Choices

Stabilization and Monitoring. If the individual's support needs are one (1) hour per week or less, Job Coaching through monthly Stabilization and Monitoring will be authorized as defined and stated above. This requires a minimum of one (1) monthly face-to-face contact with the member, one (1) monthly contact with the employer (does not have to be face-to-face), and ability of the provider to respond as needed to prevent loss of individualized integrated employment or self-employment and, where necessary, pursue a change in service authorization as needed to address longer-term challenges to avoiding loss of employment/self-employment. Other contacts can occur as needed or requested but do not need to occur face-to-face.

EMPLOYMENT SERVICES AND SUPPORTS

Supported Employment—Individual Employment Support

Supported Employment—Individual Employment Support services are individualized and may include one or more of the following components:

2. Benefits Counseling:

A service designed to inform the individual (and guardian, conservator and/or family, if applicable) of the multiple pathways to ensuring individualized integrated employment or self- employment results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This service should also repudiate myths and alleviate fears and concerns related to seeking and working in individualized integrated employment or self- employment through an accurate, individualized assessment. The service provides information to the individual (and guardian, conservator and/or family, if applicable) regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, CHOICES, housing subsidies, food stamps, etc.

The service also will provide information and education to the person (and guardian, conservator and/or family, if applicable) regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking individualized integrated employment or self-employment, or career advancement in either of these types of employment.

This service is provided by a certified Community Work Incentives Coordinator (CWIC) or certified Work Incentive Practitioner (WIP-C). In addition to ensuring this service is not otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), CHOICES may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual.

Service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation/interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.

Benefits Counseling services are ~~paid for on an hourly basis and limited in the following ways:~~ limited to 60 hours every 365 days.

~~a. Initial Benefits Counseling for someone actively considering or seeking individualized integrated employment or self-employment, or career advancement in these types of employment: up to twenty (20) hours. This service may be authorized no more than once every two (2) years (with a minimum of two 365-day intervals between services).~~

~~b. Supplementary Benefits Counseling for someone evaluating an individualized integrated job offer/promotion or self-employment opportunity: up to an additional six (6) hours. This service may be authorized up to three (3) times per year if needed.~~

~~c. PRN Problem-Solving services for someone to maintain individualized integrated employment or self-employment: up to eight (8) hours per situation requiring PRN assistance. This service may be authorized up to four (4) times per year if necessary for the individual to maintain individualized integrated employment or self-employment.~~

EMPLOYMENT & DAY SUPPORTS

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

Enabling technology options include:

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

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

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

Attachment H
Employment and Community First CHOICES Service Definitions

Stabilization and Monitoring. If the individual's support needs are one (1) hour per week or less, Job Coaching through monthly Stabilization and Monitoring will be authorized as defined and stated above. This requires a minimum of one (1) monthly face-to-face contact with the member, one (1) monthly contact with the employer (does not have to be face-to-face), and ability of the provider to respond as needed to prevent loss of individualized integrated employment or self-employment and, where necessary, pursue a change in service authorization as needed to address longer-term challenges to avoiding loss of employment/self-employment. Other contacts can occur as needed or requested but do not need to occur face-to-face.

A. Employment Services and Supports

Supported Employment—Individual Employment Support

Supported Employment—Individual Employment Support services are individualized and may include one or more of the following components:

1. Exploration:

This is a time-limited and targeted service designed to help a person make an informed choice about whether s/he wishes to pursue individualized integrated employment or self- employment, as defined above. The Exploration service shall be completed no more than ~~thirty (30)~~ sixty (60) calendar days from the date of service initiation. This service is not appropriate for ECF members who already know they want to pursue individualized integrated employment or self- employment.

This service includes career exploration activities to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to individualized integrated employment or self-employment. This service also includes exploration of individualized integrated employment or self-employment opportunities in the local area that are specifically related to the person's identified interests, experiences and/or skills through four to five uniquely arranged business tours, informational interviews and/or job shadows. (Each person receiving this service should participate in business tours, informational interviews and/or job shadows uniquely selected based on his or her individual interests, aptitudes, experiences, and skills most transferable to employment. All persons should not participate in the same experiences.) Each business tour, informational interview and/or

job shadow shall include time for setup, prepping the person for participation, and debriefing with the person after each opportunity.

This service also includes introductory education on the numerous work incentives for individuals receiving publicly funded benefits (e.g. SSI, SSDI, Medicaid, Medicare, etc.). This service further includes introductory education on how Supported Employment services work (including Vocational Rehabilitation services). Educational information is provided to the person and the legal guardian/conservator and/or most involved family member(s), if applicable, to ensure legal guardian/conservator and/or family support for the person's choice to pursue individualized integrated employment or self-employment. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the person and the legal guardian/conservator and/or most involved family member(s), if applicable.

This service is expected to involve, on average, forty (40) hours of service. The provider shall document each date of service, the activities performed that day, and the duration of each activity. This service culminates in a written report summarizing the process and outcomes, using a standard template prescribed by TennCare. The written report is due no later than fourteen (14) calendar days after the last date of service is concluded. Exploration is paid on an outcome basis, after the written report is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services) and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment.

2. Benefits Counseling:

A service designed to inform the individual (and guardian, conservator and/or family, if applicable) of the multiple pathways to ensuring individualized integrated employment or self- employment results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This service should also repudiate myths and alleviate fears and concerns related to seeking and working in individualized integrated employment or self- employment through an accurate, individualized assessment. The service provides information to the individual (and guardian, conservator and/or family, if applicable) regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, ECF CHOICES, housing subsidies, food stamps, etc.

The service also will provide information and education to the person (and guardian, conservator and/or family, if applicable) regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking individualized integrated employment or self-employment, or career advancement in either of these types of employment.

This service is provided by a certified Community Work Incentives Coordinator (CWIC) or certified Work Incentive Practitioner (WIP-C). In addition to ensuring this service is not otherwise available to

the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), ECF CHOICES may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual.

Service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation/interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.

Benefits Counseling services are ~~paid for on an hourly basis and limited in the following ways:~~ limited to 60 hours every 365 days.

~~a. Initial Benefits Counseling for someone actively considering or seeking individualized integrated employment or self-employment, or career advancement in these types of employment: up to twenty (20) hours. This service may be authorized no more than once every two (2) years (with a minimum of two 365-day intervals between services).~~

~~b. Supplementary Benefits Counseling for someone evaluating an individualized integrated job offer/promotion or self-employment opportunity: up to an additional six (6) hours. This service may be authorized up to three (3) times per year if needed.~~

~~c. PRN Problem Solving services for someone to maintain individualized integrated employment or self-employment: up to eight (8) hours per situation requiring PRN assistance. This service may be authorized up to four (4) times per year if necessary for the individual to maintain individualized integrated employment or self-employment.~~

Attachment L
Glossary of Terms for Katie Beckett Program

Minor Home Modifications (limited to children enrolled in Katie Beckett Part A or Part B): As defined in Attachment E with a limit of ~~$6,000 per project,~~ $10,000 per calendar year, and $20,000 per lifetime.

Attachment B
Data Analysis

Budget Neutrality Summary

Main Budget Neutrality Test

Without-Waiver Total Expenditures

Medicaid per capita	DEMONSTRATION YEARS (DY) DY 01 (1/2021 - 12/2021)	DY 02 (1/2022 - 12/2022)	DY 03 (1/2023 - 12/2023)	DY 04 (1/2024 - 12/2024)	DY 05 (1/2025 - 12/2025)	TOTAL
EG1 Disabled	$ 3,017,060,759	$ 3,140,486,155	$ 3,211,271,388	$ 3,032,430,428	$ 3,196,186,198	$ 15,597,434,928
EG2 Over 65	$ 3,163,633	$ 4,039,735	$ 4,738,929	$ 4,265,203	$ 4,457,147	$ 20,664,646
EG3 Children	$ 2,571,063,611	$ 2,818,701,776	$ 3,027,678,827	$ 2,724,804,006	$ 2,874,702,221	$ 14,016,950,440
EG4 Adults	$ 2,821,423,501	$ 3,331,525,475	$ 3,635,254,846	$ 2,624,435,429	$ 2,763,507,619	$ 15,176,146,869
EG5 Duals	$ 1,847,770,087	$ 2,056,626,752	$ 2,300,929,452	$ 2,434,528,630	$ 2,568,419,631	$ 11,208,274,553
Hospital Pool Adjustment (DSH)	$ 508,936,029	$ 508,936,029	$ 508,936,029	$ 508,936,029	$ 508,936,029	$ 2,544,680,145
TOTAL	$ 10,769,417,620	$ 11,860,315,922	$ 12,688,809,470	$ 11,329,399,725	$ 11,916,208,845	$ 58,564,151,582

With-Waiver Total Expenditures

Medicaid per capita	DEMONSTRATION YEARS (DY) DY 01 (1/2021 - 12/2021)	DY 02 (1/2022 - 12/2022)	DY 03 (1/2023 - 12/2023)	DY 04 (1/2024 - 12/2024)	DY 05 (1/2025 - 12/2025)	TOTAL
EG1 Disabled	$ 2,314,684,752	$ 2,433,451,050	$ 2,666,485,431	$ 2,590,246,039	$ 2,736,758,341	$ 12,741,625,614
EG2 Over 65	$ 1,721,437	$ 2,079,547	$ 3,165,333	$ 2,979,453	$ 3,128,426	$ 13,074,196
EG3 Children	$ 2,166,761,364	$ 2,512,213,316	$ 2,825,087,459	$ 2,635,932,204	$ 2,767,728,814	$ 12,907,723,157
EG4 Adults	$ 2,222,558,230	$ 2,642,539,492	$ 3,067,915,563	$ 2,348,790,096	$ 2,469,229,601	$ 12,751,032,981
EG5 Duals	$ 1,228,892,911	$ 1,487,990,029	$ 910,862,530	$ 942,309,391	$ 994,424,861	$ 5,564,479,722
Medicaid aggregate - WW only						
Virtual DSH Pool	$ 362,817,037	$ 344,181,943	$ 332,306,259	$ 344,000,000	$ 344,000,000	$ 1,727,305,239
EG12E Carryover	$ 88,254,642	$ 82,163,859	$ 57,087,223	$ 76,501,772	$ 80,326,861	$ 384,334,357
EG14E Medicaid Diversion	$ 5,625,414	$ 13,834,310	$ 27,636,839	$ 47,827,296	$ 50,218,661	$ 145,142,520
EG17E Less than MEC Additions	$ -	$ -	$ -	$ -	$ -	$ -
UC Pool	$ 222,801,080	$ 252,846,858	$ 552,908,007	$ 252,000,000	$ 252,000,000	$ 1,532,555,945
DSIP	$ 433,982,720	$ 440,800,522	$ -	$ -	$ -	$ 874,783,242
GME	$ 25,000,000	$ 40,000,005	$ 78,400,921	$ 80,000,000	$ 80,000,000	$ 303,400,926
TOTAL	$ 9,073,099,587	$ 10,252,100,931	$ 10,521,855,565	$ 9,320,586,251	$ 9,777,815,564	$ 48,945,457,898
BN VARIANCE	$ 1,696,318,033	$ 1,608,214,991	$ 2,166,953,905	$ 2,008,813,474	$ 2,138,393,281	$ 9,618,693,683

Hypothetical Budget Neutrality Test

HYPOTHETICALS ANALYSIS 1:

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 01 (1/2021 - 12/2021)	DY 02 (1/2022 - 12/2022)	DY 03 (1/2023 - 12/2023)	DY 04 (1/2024 - 12/2024)	DY 05 (1/2025 - 12/2025)	TOTAL
EG6E Expansion Adult	$ 132,966	$ 132,966	$ 132,966	$ 132,966	$ 132,966	$ 664,830
EG7E Expan Child	$ 3,908,018	$ 4,122,958	$ 4,349,721	$ 4,588,956	$ 4,841,348	$ 21,811,001
EG8 Med Exp Child	$ -	$ -	$ -	$ -	$ -	$ -
EG9 H-Disabled	$ 22,755,761	$ 23,984,572	$ 25,279,739	$ 26,644,845	$ 28,083,666	$ 126,748,583
EG10 H-Over 65	$ 5,012,991	$ 5,238,576	$ 5,474,312	$ 5,720,656	$ 5,978,085	$ 27,424,620
EG11 H-Duals	$ 375,438,140	$ 396,087,237	$ 417,872,035	$ 440,854,997	$ 465,102,022	$ 2,095,354,431
EG13 Katie Beckett Part A	$ 37,944,000	$ 39,992,976	$ 42,152,597	$ 44,428,837	$ 46,827,994	$ 211,346,404
EG15 Katie Beckett Part C	$ 187,149	$ 197,255	$ 207,907	$ 219,134	$ 230,967	$ 1,042,412
EG16 MEC Additions	$ -	$ -	$ -	$ -	$ -	$ -
						$ -
TOTAL	$ 445,379,025	$ 469,756,540	$ 495,469,277	$ 522,590,391	$ 551,197,048	$ 2,484,392,281

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 01 (1/2021 - 12/2021)	DY 02 (1/2022 - 12/2022)	DY 03 (1/2023 - 12/2023)	DY 04 (1/2024 - 12/2024)	DY 05 (1/2025 - 12/2025)	TOTAL
EG6E Expansion Adult	$ 10,851	$ 739	$ -	$ -	$ -	$ 11,590
EG7E Expan Child	$ 3,567,466	$ 4,974,602	$ 6,307,999	$ 12,409,292	$ 13,029,757	$ 40,289,116
EG8 Med Exp Child	$ -	$ -	$ -	$ -	$ -	$ -
EG9 H-Disabled	$ 29,714,095	$ 35,706,376	$ 38,794,031	$ 45,111,008	$ 47,366,558	$ 196,692,068
EG10 H-Over 65	$ 2,553,741	$ 2,818,741	$ 1,892,819	$ 3,174,480	$ 3,333,204	$ 13,772,985
EG11 H-Duals	$ 345,356,110	$ 380,086,549	$ 207,677,850	$ 283,753,130	$ 297,940,787	$ 1,514,814,426
EG13 Katie Beckett Part A	$ 4,978,103	$ 10,601,681	$ 13,399,379	$ 20,000,000	$ 21,000,000	$ 69,979,163
EG15 Katie Beckett Part C	$ 38,274	$ 4,895	$ (376)	$ -	$ -	$ 42,793
EG16 MEC Additions	$ -	$ -	$ -	$ -	$ -	$ -
						$ -
TOTAL	$ 386,218,640	$ 434,193,583	$ 268,071,702	$ 364,447,910	$ 382,670,306	$ 1,835,602,141
HYPOTHETICALS VARIANCE	$ 59,160,385	$ 35,562,957	$ 227,397,575	$ 158,142,481	$ 168,526,743	$ 648,790,141

HYPOTHETICALS ANALYSIS 2:

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 01 (1/2021 - 12/2021)	DY 02 (1/2022 - 12/2022)	DY 03 (1/2023 - 12/2023)	DY 04 (1/2024 - 12/2024)	DY 05 (1/2025 - 12/2025)	TOTAL
Carry Over Savings	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 3,052,500,955
TennCare II Medicaid Maintenance	$ -	$ -	$ -	$ -	$ -	$ -
Uncompensated Care Fund Maintenance	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 3,052,500,955

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 01 (1/2021 - 12/2021)	DY 02 (1/2022 - 12/2022)	DY 03 (1/2023 - 12/2023)	DY 04 (1/2024 - 12/2024)	DY 05 (1/2025 - 12/2025)	TOTAL
TennCare II Medicaid Maintenance	$ -	$ -	$ -	$ -	$ -	$ -
Uncompensated Care Fund Maintenance	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ -	$ -	$ -	$ -	$ -	$ -
HYPOTHETICALS VARIANCE	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 610,500,191	$ 3,052,500,955