

Title: Behavior Services

Service Definition (Scope):

Behavior Services shall mean:

- a. Services to assess and ameliorate person supported behavior that jeopardizes the health and safety of the person supported, that endangers others, or that prevents the person supported from being able to successfully participate in community activities; and
- b. Development, monitoring, and revision of behavior intervention strategies, including development of a Behavior Support Plan and staff instructions for caregivers who are responsible for implementation of prevention and intervention strategies; and
- c. The initial training of caregivers on the appropriate implementation of behavior intervention strategies, including the Behavior Support Plan (BSP) and staff instructions.

The BSP shall be developed through the person-centered planning process in collaboration with the person receiving the services, family members, the conservator if applicable and others selected by the person who will be supporting the person receiving the services, and responsible for implementing the BSP.

Therapeutic goals and objectives shall be required for persons supported receiving Behavior Services. Behavior Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Speech, Language, and Hearing Services, unless there is documentation in the person's record of medical justification for the two services to be provided concurrently. Behavior Services shall be provided by a Behavior Analyst face to face with the person supported except for:

- (a) Completion of the Behavior Assessment Report; and
- (b) Person supported-specific training of staff, except in instances when the Behavior Analyst can demonstrate appropriate interventions in real time; and
- (c) Presentation of behavior information of the person supported at human rights committee meetings, behavior support committee meetings, and planning meetings related to the person supported.

Reimbursement for presentation of behavior information related to the person supported at meetings shall be limited to a maximum of 5 hours per person supported per calendar year per provider.

Behavior assessments, behavior plan development, and presentations at meetings shall not be performed by Behavior Specialists. Behavior specialists are responsible for providing training, data collection and plan implementation but only behavior analysts can conduct a behavior assessment and develop the behavior support plan.

Reimbursement for behavior assessments shall be limited to a maximum of 8 hours per assessment (32 qtr hour units per calendar year) with a maximum of 2 assessments per calendar year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first 30 calendar days following its approval for use shall be limited to a maximum of 6 hours (24 qtr hour units per calendar year).

Reimbursement shall not be made for travel time to meetings and for telephone consultations, but may be made for consultations with treating the physician or psychiatrist during an office visit when the person supported is present.

Reimbursement for presentation of person supported behavior information at human rights committee meetings, behavior support committee meetings, and person supported planning meetings shall be limited to 5 hours per provider (20 qtr hour units per calendar year). Behavior Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program, including psychological evaluations and psychiatric diagnostic interview examinations. Behavior Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSTDT benefits).

Applicable limits, if any, on the amount, frequency, or duration of this service:

Reimbursement limits:

- * 8 hours per assessment for completion of the behavior assessment; 2 assessments per year
- * 6 hours per assessment for behavior plan development and staff training during the first 30 days following its approval; 2 assessments per calendar year
- * 5 hours for presentations at meetings per calendar year

Title: Behavioral Respite**Service Definition (Scope):**

Behavioral Respite Services shall mean short-term behavior-oriented services for a person supported who is experiencing a behavioral crisis that requires removal from the current residential setting in order to assist in resolving the behavioral crisis. Behavioral Respite Services providers shall also help to plan, coordinate, and prepare for the individual's transition back to his/her residential setting.

Behavioral Respite Services shall be provided in a setting staffed by individuals who have received training in the management of behavioral issues. Direct support staff must have received training in the prevention and management of crisis behavior. Behavioral Respite Services may be provided in a Medicaid-certified ICF/IID, in a licensed respite care facility, or in a home operated by a licensed residential provider. Behavioral Respite Services shall not be provided in a home where a person supported lives with family members unless such family members are also persons supported receiving Behavioral Respite Services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

The Behavioral Respite Services provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not at school, including behavioral supervision and intervention for aggressive or inappropriate behavior that jeopardizes the health and safety of the person supported or others. The Behavioral Respite Services provider shall oversee health care needs of the person supported. Behavioral Respite Services providers shall be responsible for the cost of any Day Services needed while the person supported is receiving Behavioral Respite Services.

Reimbursement for Behavioral Respite Services shall not include payment for Behavioral Respite Services provided by the spouse of a person supported. The Behavioral Respite Services provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Behavioral Respite Services provided by such individuals.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Behavioral Respite Services and shall be included in the reimbursement rate for such. A person supported who is receiving Behavioral Respite Services shall not be eligible to receive Personal Assistance, Respite, or Day Services (which would duplicate services that are

the responsibility of the Behavioral Respite Services provider). Restraints shall not be used unless used in accordance with the Department's policy on use of restraints.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Behavioral Respite Services shall be limited to a maximum of 60 days per person supported per waiver (i.e., calendar) year.

Title: Employment and Day Services

Service Definition (Scope):

Employment and Day Services shall mean individualized services and supports selected by the person supported, that help the person to seek employment and work in competitive integrated settings and engage in community life, based on his or her individualized needs and preferences and as reflected in the person-centered ISP, and to acquire, retain, or improve skills in the area of self-care, sensory/motor development, socialization, daily living skills, and communication, in order to pursue and achieve his or her personal employment and/or community living goals. All individual employment and day services goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual.

Employment and Day Services shall be provided as specified in the person-centered ISP in order to support the individual's employment and/or community living activities, or the development, retention, and improvement of skills necessary to achieve employment and/or community living goals. Day Services may be provided to persons as a separate service where permitted under service specifications described in this waiver.

Supported Employment shall be the preferred option for all persons supported that are not of retirement age, based on each person's needs and preferences, and shall be provided in accordance with the following requirements:

- a. A job coach employed by the Day Services provider shall be on-site at the work location and shall support the person; or
- b. The Day Services provider shall oversee the person's supported employment services including on-site supervisors, and shall have a minimum of one contact per week with the person including at least one contact per month at the work site, and shall have a job coach employed by the Day Services provider who is available on-call if needed to go to the work site.

Community-based Day Services shall support each person's full engagement in community life, based on his or her individualized needs and preferences and as reflected in the person-centered ISP, and the acquisition, retention, or improvement of skills in the area of self-care, sensory/motor development, socialization, daily living skills, communication, and social skills in order to pursue and achieve his or her personal employment and/or community living goals. This includes assisting the person to build relationships and natural supports.

Community-based Day Services are designed such that the person spends the majority of his/her time, while participating in this service, actively engaged in activities in the community. Supervision, monitoring, training, education, demonstration, or support is provided to assist with the acquisition of skills in the following areas: leisure activities and community/public events, utilizing community resources (e.g. public transportation), acquiring and maintaining employment, educational activities, hobbies, unpaid work experiences (e.g. volunteer opportunities), and maintaining contact with family and friends.

Day Services may be provided in a facility setting only when selected by a person supported who needs time limited pre-vocational training, when such training is not available on the job site, and to persons who, through their person-centered planning process choose to participate in a facility based program in order to focus on the development of individualized and specific skills that will support them in pursuing and achieving employment and/or community living goals. Facility-based day services must allow for opportunities for all persons supported to be engaged in the broader community when appropriate and be specified in the person-centered ISP. Opportunities to transition into more integrated settings, including competitive integrated employment, will be evaluated on at least an annual basis. In-home Day Services are provided in the person's residence only if selected by the person supported because there is a health, behavioral, or other medical reason, or if the person has chosen retirement or is unable to participate in services outside the home.

Additional Requirements

Transportation of the person to and from the person's place of residence to the location where Day Services will be provided shall be the responsibility of the Employment or Day Services provider. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation that is needed during the time that the person is receiving Day Services shall be the responsibility of the Day Services provider, and the cost of such transportation shall be considered to be included within the Day Services reimbursement rate.

Day Services shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Day Services are not intended to replace services available through the Medicaid State Plan/TennCare program. Services provided by natural supports are not reimbursable and are excluded from reimbursement as part of this service.

Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. Day Services shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being

homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego. Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods.

The reimbursement for Supported Employment Day Services shall include incentive payments for vocational related specified, measurable outcomes such as:

- a. A one-time payment that is made to an Employment provider when an individual obtains employment as a result of that provider's direct involvement in the job placement.
- b. Stipends paid to employers that are passed through to individuals on the work site who, in addition to their regular job duties, function as a work place support for individuals served in the waiver.
- c. A one-time payment that is made to an Employment provider when an individual has been employed consecutively for one year.

The reimbursement for Supported Employment Day Services shall not include incentive payments, subsidies, or unrelated vocational training expenses: such as,

- a. Incentive payments that would duplicate or replace milestone payments made by Vocational Rehabilitation.
- b. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
- c. Payments that are passed through to users of supported employment programs.
- d. Payments for vocational training that is not directly related to a person's supported employment program.

Day Services shall be limited to a maximum of 5 days per week up to a maximum of 243 days per person per calendar year. Family members who provide Day Services are required to implement services as specified in the Individual Support Plan (ISP). Reimbursement to family members shall be limited to forty (40) hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

Day Services shall be reimbursed in accordance with the requirements set forth herein. The provider may receive the per diem reimbursement for Day Services if:

- a. The person receives 6 hours of direct services, which may include, in accordance with requirements specified herein, combinations of Supported Employment, Community-based, Facility-based, and In-home Day Services.
- b. The person receives at least 2 hours of Day Services and there is documentation that the person was unable to complete the full 6 hours of Day Services for reasons beyond the provider's control (e.g., sickness of the person).

Reimbursement for a combination of different Day Services (e.g., supported employment, community-based, and/or facility-based; or community-based and/or facility-based in conjunction with in-home) provided on the same day shall be made in accordance with the following:

- a. If the person receives up to or in excess of 6 hours of a combination of Community-based and Facility-based Day Services, the reimbursement shall be the per diem reimbursement rate for the type of service provided for the greatest amount of time that day.
- b. If the person receives up to or in excess of 6 hours of a combination of Day services that includes Supported Employment, the reimbursement shall be the per diem reimbursement rate for Supported Employment Day Services.
- c. Only in the case of a person who has chosen retirement and to encourage the person's continued participation in community life, if the person receives at least 2 hours of Community-Based Day Services in order to participate in integrated community activities of his/her choosing, and chooses to receive some or all of the remainder of the 6 hours receiving In-home Day Services, the reimbursement shall be the per diem reimbursement rate for Community-Based Day Services.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Day Services shall be limited to a maximum 5 days per week up to a maximum of 243 days per service recipient per year.

Title: Dental Services

Service Definition (Scope):

Dental Services preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection) which have dental procedure codes listed in the current TennCare Maximum Reimbursement Rate Schedule for Dental Services that is used specifically for HCBS waiver dental services; and

b. Intravenous sedation or other anesthesia services provided in the dentist's office by, and billed by, the dentist or by a nurse anesthetist or anesthesiologist who meets the waiver provider qualifications. Orthodontic services are excluded from coverage.

Dental Services are not intended to replace services available through the Medicaid State Plan/TennCare program. All Dental Services for children enrolled in the waiver are provided through the TennCare EPSDT program. Dental Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Dental residents in training may provide Dental Services if they work under the direct supervision of a licensed dentist who is physically present when such services are being provided and if the licensed dentist materially participates in the provision of the Dental Services.

Applicable limits, if any, on the amount, frequency, or duration of this service: Adult Dental Services shall be limited to a maximum of \$5,000 per service recipient per waiver program year (i.e. calendar year), and a maximum of \$7,500 per service recipient across three (3) consecutive waiver program years (i.e. calendar years).

Title: Environmental Accessibility Modifications

Service Definition (Scope):

Environmental Accessibility Modifications shall only mean the following modifications to the place of residence of the person supported:

- a. Physical modifications to the interior of a place of residence to increase the mobility and accessibility within the residence of the person supported;
- b. Physical modifications to an existing exterior doorway of place of residence to increase the mobility and accessibility for entrance into and exit from the residence of the person supported;
- c. A wheelchair ramp and modifications directly related to, and specifically required for, the construction or installation of the ramp; or as an alternative to a wheelchair ramp, a platform lift (to lift wheelchairs) and modifications directly related to, and specifically required for, the installation of a platform lift for one entrance into the residence;
- d. Hand rails for exterior stairs or steps to increase the mobility and accessibility of the person supported for entrance into and exit from the residence; or
- e. Replacement of glass window panes with a shatterproof or break-resistant material when medically necessary based on a history of destructive behavior by the person supported.

The following are specifically excluded from coverage:

- a. Any adaptation or modification of the home which is of general utility and is not of direct medical or remedial benefit to the person supported;
- b. Any adaptation or modification which is considered to be general maintenance of the residence;
- c. Any physical modification to the exterior of the place of residence or lot of the person supported (e.g., driveways, sidewalks, fences, decks, patios, porches) that is not explicitly listed above as being covered;
- d. Any physical modification to garage doors for entry of vehicles;
- e. Any item that would be covered by the Medicaid State Plan/TennCare Program;
- f. Construction of an additional room or modification of an existing room which increases the total square footage of the residence;

- g. Construction of a new room within existing floor space (e.g., construction of an additional bathroom), including construction of new interior walls to subdivide existing rooms;
- h. A second or additional wheelchair ramp when there is a functional wheelchair ramp for one entrance into the residence of the person supported;
- i. A wheelchair ramp when there is a functional platform lift (to lift wheelchairs) for one entrance into the residence of the person supported; or a platform lift for entrance into the residence when there is a functional wheelchair ramp for one entrance into the residence;
- j. Platform lifts for use inside the place of residence of the person supported;
- k. Stairway lifts, stair glides, or elevators or the installation, repair, or replacement of stairway lifts, stair glides, or elevators;
- l. Repair or replacement of roofing or siding;
- m. Installation, repair, replacement, or painting of ceiling, walls, or floors or installation, repair, or replacement of carpet or other flooring except:
 - (1) When the need for such is directly related to and necessitated by another approved environmental accessibility modification (e.g., flooring or carpet repair when a doorway is widened); and
 - (2) When the cost of such is included in the cost of the other approved environmental accessibility modification;
- n. Rugs and floor mats;
- o. Furniture, lamps, beds, mattresses, bedding, and over bed tables;
- p. Water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
- q. Air conditioning or heating systems or units or the installation, repair, or replacement of air conditioning or heating systems or units;
- r. Electrical generators; emergency electrical backup systems; batteries, or battery chargers;
- s. Installation, repair, or replacement of electrical units or systems, except for the installation or replacement of electrical outlets which will be used for medical equipment;

- t. Lights or lighting systems or the installation, repair, or replacement of lights or lighting systems; except for the installation or replacement of lights when the need for such is directly related to and necessary in order to complete another approved environmental accessibility modification;
- u. Construction of additional exterior doorways or windows;
- v. Any item that meets the waiver service definition of Specialized Medical Equipment, Supplies, and Assistive Technology;
- w. Sprinklers and sprinkler systems; and
- x. Costs for removing an Environmental Accessibility Modification in order to convert or otherwise restore the place of residence to its pre-existing condition (i.e., the condition before the modification was made).

Environmental Accessibility Modifications shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist). To facilitate community transition of a Medicaid eligible person residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other institutional setting who has been determined to qualify for HCBS waiver services upon discharge, Environmental Accessibility Modifications may be made to the place of residence of the persons supported during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. In such cases, the Environmental Accessibility Modification will not be considered complete until the date the person leaves the ICF/IID or other institutional setting and is enrolled in the waiver, and such date shall be the date of service for billing purposes.

Environmental Accessibility Modifications shall be available only for newly enrolled waiver participants, including (but not limited to) persons transitioning to the community from an institutional setting, and existing waiver participants who have recently experienced a significant loss of mobility function. Environmental Accessibility Modifications shall be limited to a maximum of \$15,000 per person supported per three (3) consecutive waiver program years (calendar years).

Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the Department's policy on submission of bids. If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for an Environmental Accessibility Modification or the request will be denied. If the person supported does not own the place of residence, there must be written approval from the landlord for the Environmental Accessibility Modification to be approved.

Such written approval must acknowledge that the person supported will not be responsible for the costs of removing an Environmental Accessibility Modification in order to convert or otherwise restore the place of residence to its pre-existing condition.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Environmental Accessibility Modifications shall be limited to a maximum of \$15,000 per service recipient per three (3) consecutive waiver program years (i.e. calendar years).

Title: Family Model Residential Support

Service Definition (Scope):

Family Model Residential Support shall mean a type of residential service selected by the person supported, where he or she lives in the home of a trained caregiver who is a not family member in an “adult foster care” arrangement. A family member(s) of the persons supported shall not be reimbursed to provide Family Model Residential Support services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

In this type of shared living arrangement, the caregiver allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and family, supports each resident’s independence and full integration into the community, ensures each resident’s choice and rights, and supports each resident in a manner that comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual’s specific assessed need and set forth in the person centered ISP planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. Family Model Residential Support includes individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside successfully in a community-based setting, living in a family environment in the home of trained caregivers other than the family of origin.

Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual’s rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Family Model Residential Supports may include medication administration as permitted under Tennessee’s Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

The Family Model Residential Support caregiver shall oversee the health care needs of the person supported. The Family Model Residential Support provider agency shall not find, purchase, or lease a residence in which Family Model Residential Supports will be provided. Family Model Residential Support caregivers shall be recruited, screened, contracted, and trained prior to providing services, and monitored by the Family Model Residential Support provider agency to ensure compliance with licensing and program requirements. The Family Model Residential Support provider agency shall facilitate matching of persons supported and caregivers but shall not determine whether a caregiver chooses to participate in the program, whether a caregiver will bring a particular person supported into his or her home, or how the day-to-day activities of the home and provision of services and supports will occur. Visits, both announced and unannounced, and phone calls to the home must occur on a regular basis in order for the provider agency to ensure compliance with program requirements and the general health and safety of the person supported, but should not be so prescriptive as to instruct the provider about particular tasks to perform or ways to fulfill or not fulfill duties. Family Model Support caregivers are responsible for abiding by the quality assurance standards, outlined in the DIDD Provider Manual, which are monitored and enforced by DIDD.

A Family Model Residential Support home shall have no more than 3 residents who receive services and supports regardless of HCBS program or funding source. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such.

Family Model Residential Support shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Reimbursement for Family Model Residential Support shall not include payment for Family Model Residential Support provided by the spouse of a person supported. The Family Model Residential Support provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Family Model Residential Support provided by such individuals. Reimbursement for Family Model Residential Support shall not include payment made to any other individual who is a conservator, unless so permitted in the Order for Conservatorship. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling.

Family Model Residential Support may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.

b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).

c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver.

The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Individual Transportation Services

Service Definition (Scope):

Individual Transportation Services shall mean non-emergency transport of a person supported to and from approved activities specified in the ISP. Whenever possible, immediate family members, friends who are involved in providing supports and community agencies who can provide this service without charge should be utilized.

The following transportation services are excluded from coverage:

a. Transportation to and from medical services covered by the Medicaid State Plan/TennCare Program; and

b. Transportation of school aged children to and from school; and

c. Transportation to and from supported or competitive employment; and

d. Transportation that is the responsibility of the provider of a residential service (e.g., Residential Habilitation, Medical Residential Services, Family Model Residential Support, or Supported Living) or that is the responsibility of the provider of Day Services or Behavioral Respite Services, since it would duplicate services that are the responsibility of such providers.

Individual Transportation Services shall not be provided by the spouse of a person supported and shall not be provided by the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption, and reimbursement shall not be provided for Individual Transportation Services provided by such individuals.

Applicable limits, if any, on the amount, frequency, or duration of this service: Limited to 31 days/month maximum.

Title: Intensive Behavioral Residential Services

Service Definition (Scope):

Intensive Behavioral Residential Services is a home and community-based clinical treatment model selected by the person supported, or their representative, as appropriate, designed to meet the specific and individualized assessed needs of each person receiving the service and which supports, to the maximum extent appropriate, each resident's independence and full integration into the community; ensures, to the maximum extent appropriate, each resident's choice and rights; and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

This service is appropriate for individuals who have exhibited high risk behavior, placing themselves and or others in danger of harm, and whose person-centered plan reflects the positive interventions and supports used prior to this service, and less intrusive methods of meeting the need that have been tried but did not work. This service is designed to be flexible enough to respond to the changing levels of need of the person supported and the level of risk presented by the person's current behavior, with the goal of helping the person transition to a more integrated setting in the future. It is not an indefinite, long term, residential support service.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include, to the maximum extent appropriate and preferred by the individual, opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources. A person with high risk behavior receiving Intensive Behavioral Residential Services will have opportunities to develop a lifestyle which includes developing healthy and meaningful relationships with others.

Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Leadership of this service is provided by the agency Clinical Director, who is responsible for ensuring service quality and providing clinical oversight of clinical and direct support staff. Administrative functions are performed by members of the agency management team.

1. Providers are licensed and operated as a mental retardation (i.e. Intellectual Disability) Residential Habilitation Facility.

2. Each residence is no larger than a four-person home.
3. Each home may have at least one safe area that provides a room or space to which a person may (based on his or her individualized needs as reflected in the person-centered plan) retreat in order to prevent or manage an escalating behavior.
4. The service:
 - a. Includes an individual treatment plan which describes ongoing assessment and monitoring of the person supported and professional judgment regarding behavioral supervision, individual crisis plans, treatment objectives, and treatment planning. The individual treatment plan does not replace the federally required individual support plan. Rather, it describes in detail the person's treatment needs, etc., as described above.
 - b. Allows for persons supported to learn and complete activities of daily living necessary for successful social integration.
 - c. Has staffing ratios that are designed to be flexible in order to meet the needs of people as events occur.
 - d. Coordinates ancillary services that are flexible and responsive to the needs of the people supported. Ancillary services may be funded through the Managed Care Organization or the Medicaid Waiver; will vary according to the person's individual needs; and may include services such as counseling, psychotherapy, psychiatric consultation, medical, dental, and nursing and therapy services.
 - e. Provides behavior analyst services that are embedded within the service and are flexible and available as needed within a 24-hour period.
 - f. Ensures that DIDD Human Rights Committee and DIDD Behavior Support Committee approval is obtained prior to implementation of restrictive interventions, as necessary.
5. On-going safety and supervision may include any combination of the following components as determined through the person-centered planning process and documented in the person's ISP and treatment plan:
 - a. An intensive person-centered planning approach including determining what is important to and for the person and supporting him/her to achieve those goals identified in this process.
 - b. A carefully structured environment and a highly structured schedule with pre-planned activities, which the person supported participates in choosing and scheduling.

- c. Proactive behavioral intervention approaches and teaching alternative strategies.
 - d. Learning healthy methods of expression.
 - e. Remote monitoring in public areas of the home.
 - f. Alarms to notify staff of elopement.
 - g. Windows designed for safety.
 - h. Other measures as recommended and approved.
6. Daily activities may include but are not limited to the following:
- a. Supported employment when appropriate.
 - b. The training of self-management.
 - c. Training in essential life skills to attain or maintain integration in the community.
 - d. Habilitation, based upon individual needs and program strategies, to teach tasks that will assist the person in getting ready for a typical workday (e.g., making lunch, using public transportation, etc.)
 - e. Community exploration and integration.

The IBRS provider shall be responsible for the cost of Day Services needed by the person supported and any Behavior Services needed while receiving Day Services. This service is appropriate for individuals who exhibit high risk behaviors that are dangerous or whose behaviors are so serious that when they occur, they present a potential danger to the person, staff, or the community. Examples of the behaviors that meet criteria are behaviors that have caused harm in the past (e.g., sexual predatory behavior) and have a probability of reoccurrence. These behaviors can be reasonably expected to occur in the absence of a highly structured therapeutic environment without support, supervision, and training in alternative behaviors. Specific examples include the following:

1. Directly causes serious injury of such intensity as to be life threatening or demonstrates the propensity to cause serious injury to self, others, or animals.
2. Sexually offensive behaviors with high frequency of occurrence or sexual behavior with any person who did not consent or is unable to consent to such behavior, or engaging in public displays of sexual behavior.
3. Criminal behavior.
4. Cause serious property destruction (e.g., fire setting).

Clinical Review Process

The DIDD Central Office Clinical Review Committee is responsible for reviewing and approving each person who is referred for this service. Referrals will be generated from persons supported who have been served at the highest levels of need (LON) in terms of intensity, supports, and services, yet have received minimal benefit from services at said level, and for whom Intensive Behavioral Residential Services offer a more appropriate and cost effective

service delivery model. Referrals may also be generated for persons entering the system who have issues identified that are consistent with those noted for the target population and for whom Intensive Behavioral Residential Services offer a more appropriate and cost-effective service delivery model than services the person would otherwise require.

The DIDD Central Office Clinical Review Committee will review referrals from state case managers, independent support coordinators, and DIDD providers. The DIDD Central Office Clinical Review Committee is comprised of the Director of Behavioral and Psychological Services (Chair), selected clinicians, and DIDD central/regional office staff. For each person referred for this service, the committee will review the following information: intake plan, individual support plan (ISP), risk assessment, clinical assessments, and health evaluations. IBRS may be selected by the individual and offered only after alternative approaches have been tried and documented to be unsuccessful.

1. Continuing this service requires periodic (at least every six months or more frequently, as needed) evaluation by the agency Clinical Director, and approval by the DIDD Central Office Clinical Review Committee of the continued likelihood of occurrence of presenting behaviors and progress/benefit in continuing the program and the continuing need for structure and protections provided under this model. The agency Clinical Director shall submit recommendations regarding continued stay or discharge to the DIDD Central Office Clinical Review Committee, who shall make the final determination.

2. An individual may choose to no longer receive this service at any time, or otherwise shall be considered to no longer require this service if the individual has met the clinical objectives identified in the clinical plan such that the structure and protections afforded under this model are no longer appropriate, or the individual/legal representative has refused to participate in treatment.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Medical Residential Services

Service Definition (Scope):

Medical Residential Services shall mean a type of residential service selected by the person supported, encompassing the provision of direct skilled nursing services and habilitative services and supports that enable a person supported to acquire, retain, or improve skills necessary to reside in a community-based setting, and which supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

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

Medical Residential Services must be medically necessary and provided in accordance with the person-centered ISP. The person supported who receives Medical Residential Services must have a medical diagnosis and treatment needs that would justify the provision of direct skilled nursing services that must be provided directly by a registered nurse or a licensed practical nurse, and such services must be needed on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits and which cannot be more cost-effectively provided through a combination of waiver services and other available services. There must be an order by a physician, physician assistant, or nurse practitioner for one or more specifically identified skilled nursing services, excluding nursing assessment or oversight, that must be provided directly by a registered nurse or by a licensed practical nurse in accordance with the Tennessee Nurse Practice Act.

The Medical Residential Services provider may elect to have the Nurse also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the individual during the period that Medical Residential Services are authorized and provided, unless such assistance cannot be safely provided by the nurse while also attending to the individual's skilled nursing needs. However, the need for Medical Residential services shall depend only on the skilled nursing needs of the individual. Medical Residential services shall be provided in an appropriately licensed Residential Habilitation or Supported Living home.

The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports, including skilled nursing services, up to 24 hours per day 7 days a week when the person supported is not at school, based on the individualized needs of each resident; however, a nurse is not required to be present in the home during those time periods when skilled nursing services are not medically necessary. One nurse can provide services to more than one person supported in the home during the same time period if it is medically appropriate to do so. The Medical Residential Services provider shall be responsible for the cost of Day Services needed by the person supported and any skilled nursing services needed while receiving Day Services.

Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Medical Residential Services may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Medical Residential provider shall oversee the health care needs of the person supported. A Medical Residential Services home shall have no more than 4 residents with the exception of those homes which were licensed as a Residential Habilitation Facility prior to July 1, 2000. Individuals receiving Medical Residential services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

Medical Residential Services shall not be provided in schools or in institutional settings (e.g., inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities). Medical Residential Services shall not be provided in a home where a person supported lives with family members unless such family members are also HCBS persons supported. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption. Since the Medical Residential Services provider is responsible for providing direct support services, Day Services, and other services 24 hours per day 7 days per week when the person supported is not at school, a person supported who is

receiving Medical Residential Services shall not be eligible to receive Personal Assistance, Day Services, or Respite.

Medical Residential Services are not intended to replace services available through the Medicaid State Plan/TennCare Program. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such. Reimbursement for Medical Residential Services shall not be made for room and board or for the cost of maintenance of the dwelling if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the person supported, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the person supported and who provides services to the person supported in the place of residence of the person supported. If a person supported owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported, other residents in the home, and (as applicable) live-in or other caregivers.

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

Medical Residential Services may be provided out-of-state under the following circumstances:

- a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.
- b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider)..
- c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of- state services shall not be reimbursed through the waiver.

The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Nursing Services

Service Definition (Scope):

Nursing Services shall mean skilled nursing tasks that must be performed by a registered or licensed nurse pursuant to Tennessee's Nurse Practice Act and that are directly provided to the person supported in accordance with a person-centered ISP. Nursing Services shall be ordered by the physician, physician assistant, or nurse practitioner of the person supported, who shall document the medical necessity of the services and specify the nature and frequency of the skilled nursing tasks to be performed. Nursing Services shall be provided face to face with the person supported by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

Nursing Services shall also include the provision of services to teach and train the person supported and their family or other paid or unpaid caregivers how to manage the treatment regimen, and the provision of evaluation and training, specific to an individual person supported, by a registered nurse, for purposes of delegation of noncomplex health maintenance tasks to unlicensed direct support staff, as determined appropriate by the delegating nurse, and as permitted by State law and contingent upon the registered nurse's evaluation of each individual's condition and also upon the registered nurse's evaluation of the competency of each unlicensed direct support staff.

Evaluation, teaching and training required for delegation is considered part of the established rate; it is not billed separately. The nurse shall also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the person supported during the period that Nursing Services are authorized and provided, unless such assistance cannot be safely provided by the nurse while also attending to the skilled nursing needs of the person supported (which must be documented in writing and approved pursuant to protocol). However, the amount of Nursing Services authorized and provided shall depend only on the skilled nursing needs of the person supported. Additional Nursing Services shall not be authorized only for purposes of providing unskilled needs.

A single nurse may provide services to more than one individual receiving services in the same setting, provided each person's needs can be safely and appropriately met. When Nursing Services are provided as a shared service for 2 or more individuals residing in the same home (regardless of funding source), the total number of units of shared Nursing Services shall be apportioned based on the total units of nursing services prescribed for each person supported, and the apportioned amount shall be specified in the ISP for each person supported, as applicable.

Only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported. Documentation of service delivery must be kept for each person supported and shall reflect the total number of shared units of service provided, and the specific nursing tasks performed for that individual. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

Nursing Services shall consist of 2 categories of services and reimbursement:

- a. RN services: RN services shall mean skilled nursing services, as specified above, which are provided by a registered nurse. This includes those services which require the skills of a registered nurse and which are required by Tennessee's Nurse Practice Act to be performed by a registered nurse.
- b. LPN services: LPN services shall mean skilled nursing services, as specified above, which are provided by a licensed practical nurse working under the supervision of a registered nurse and which are permitted by Tennessee's Nurse Practice Act to be performed by a licensed practical nurse working under the supervision of a registered nurse.

This service shall be provided in home and community settings, as specified in the ISP, excluding schools, inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). A person supported who is receiving Medical Residential Services shall not be eligible to receive Nursing Services. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently. Nursing Services are not intended to replace either intermittent home health skilled nursing visits or private duty nursing services available through the Medicaid State Plan/TennCare program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Nursing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSTDT benefits).

Applicable limits, if any, on the amount, frequency, or duration of this service: Nursing Services shall be limited to a maximum of 48 units (12 hours) per day per waiver participant.

Title: Nutrition Services

Service Definition (Scope):

Nutrition Services shall mean assessment of nutritional needs, nutritional counseling, and education of the person supported and of caregivers responsible for food purchase, food preparation, or assisting the person supported to eat. Nutrition Services must be provided in accordance with therapeutic goals and objectives specified in an ISP that is specific for the individual receiving services and developed by a dietitian or nutritionist. A dietitian or nutritionist who provides Nutrition Services must provide services within the scope of licensure and must be licensed as required by the State of Tennessee. Nutrition Services are intended to promote healthy eating practices and to enable the person supported and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

Nutrition Services must be provided face to face with the person supported except for training caregivers responsible for food purchase or food preparation on the specific needs of the person supported, or assisting the person supported to eat and except for that portion of the assessment involving development of the ISP. To the greatest extent possible, it is expected that the person supported is engaged in these activities as learning opportunities.

Nutrition Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Speech, Language, and Hearing Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently. The unit of reimbursement for a Nutrition Services assessment with plan development shall be per day. The unit of reimbursement for other Nutrition Services shall be per day. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one assessment visit per waiver participant (person supported) per waiver program year (calendar year).

Nutrition Services other than the assessment (e.g., person supported-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one visit per day. Nutrition Services (including Nutrition Services assessments and other non-assessment services) shall be limited to a maximum of six (6) visits per waiver participant (person supported) per waiver program year (calendar year), of which no more than one (1) visit per waiver program year (calendar year) may be an assessment.

A Nutrition Services assessment cannot be billed on the same day with other Nutrition Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Nutrition Services unless provided by a licensed dietitian or nutritionist.

Nutrition Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

Applicable limits, if any, on the amount, frequency, or duration of this service: Nutrition Services shall be limited to a maximum of six (6) visits per waiver participant per waiver program year (i.e. calendar year), of which no more than one (1) visit per waiver program year (i.e. calendar year) may be a Nutrition Services assessment. Nutrition Services other than the assessment (e.g., service recipient-specific training of caregivers; monitoring dietary compliance and food preparation) shall be further limited to a maximum of one visit per day.

Title: Occupational Therapy

Service Definition (Scope):

Occupational Therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations involving performance of activities of daily living; and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Occupational Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist. Occupational Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care.

Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted). Occupational Therapy shall be provided in accordance with a treatment plan developed by a licensed occupational therapist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Occupational Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Occupational Therapy services shall require documentation of reassessment of the condition of the person supported and continuing progress of the person supported toward meeting the goals and objectives.

Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Hearing, and Language Services; Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the person supported has a record of medical justification for the two services to be provided concurrently. Occupational Therapy is not intended to replace services that would normally be provided by direct care staff.

Occupational Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Occupational Therapy shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSTDT benefits).

The unit of reimbursement for an Occupational Therapy assessment with plan development shall be per day. The unit of reimbursement for other Occupational Therapy services shall be per 15 minutes. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Occupational Therapy services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Occupational Therapy unless provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Reimbursement limits:

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

Title: Orientation and Mobility Services for Impaired Vision

Service Definition (Scope):

Orientation and Mobility Services for Impaired Vision shall mean services (1) to assess the orientation and mobility of a person supported to determine functional limitations resulting from severe visual impairment and (2) to provide orientation and mobility training to enable a person supported with functional limitations resulting from severe visual impairment to move with greater independence and safety in the home and community environment.

Orientation and Mobility Services for Impaired Vision shall be based on a formal assessment of the person supported and may include concept development (i.e. body image); motor development (i.e., motor skills needed for balance, posture and gait); sensory development (i.e. functioning of the various sensory systems); residual vision stimulation and training; techniques for travel (indoors and outdoors) including human guide technique, trailing, cane techniques, following directions, search techniques, utilizing landmarks, route planning, techniques for crossing streets, and use of public transportation; and instructional use of Low Vision devices.

Orientation and Mobility Services for Impaired Vision shall be provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). Orientation and Mobility Services for Impaired Vision shall be provided face to face with the person supported except for training of caregivers responsible for assisting in the mobility of the person supported and except for that portion of the assessment involving development of the plan of care. Therapeutic goals and objectives shall be required for persons supported receiving Orientation and Mobility Services for Impaired Vision. Continuing approval of Orientation and Mobility Services for Impaired Vision shall require documentation of reassessment of the condition and continuing progress of the person supported toward meeting the goals and objectives.

Orientation and Mobility Services for Impaired Vision shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Behavior Services, or Speech, Language, and Hearing Services, unless there is documentation in the record of medical justification of the person supported for the two services to be provided concurrently.

Orientation and Mobility Services for Impaired Vision shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. The unit of reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with plan development shall be per day. The unit of reimbursement for other Orientation and Mobility Services for Impaired Vision shall be per 15 minutes.

Reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with development of the plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Orientation and Mobility Services for Impaired Vision assessments shall not be billed on the same day with other Orientation and Mobility Services for Impaired Vision services. Orientation and Mobility Services for Impaired Vision services other than such assessments (e.g., person supported training; person supported-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of 52 hours of services per person supported per calendar year.

Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Orientation and Mobility Services for Impaired Vision unless provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

Applicable limits, if any, on the amount, frequency, or duration of this service:

Reimbursement limits:

- * 1 assessment with plan development per month;
- * 3 assessments per year per enrollee per provider; and
- * 52 hours of non-assessment services per calendar year.

Title: Personal Assistance

Service Definition (Scope):

Personal Assistance shall mean a type of service, selected by the person supported, offering individualized services and supports that enable the person to live in the community in a setting of their choice and which supports each person's independence, rights, and full inclusion in the community; and ensures each resident's choice and rights. Personal Assistance services shall be delivered in a manner that comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. Supports may include of direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, meal preparation excluding cost of food, toileting and incontinence care, assistance with transfer and mobility), household chores essential to the health and safety of the person supported (e.g., washing dishes; personal laundry; general housecleaning in areas of the residence used by the person supported); budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), supervising and accompanying the person supported to medical appointments if needed, and on personal errands such as grocery shopping, picking up prescriptions, paying bills; and trips to the post office. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Personal Assistance may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. Personal Assistance is a service that is provided for the direct benefit of the person supported. It is not a service that provides direct assistance to other members of the household (e.g., preparation of meals for the family, family laundry) who are not persons supported through the waiver. Personal Assistance staff shall not provide any personal assistance services to family members of the person supported, unless such family members are also supported through the waiver residing in the same home (e.g., when 2 siblings in the home are both waiver participants).

A single staff person may provide Personal Assistance services to more than one individual residing in the same home at the same time, provided each person's needs can be safely and appropriately met. When Personal Assistance is provided as a shared service for 2 or more family members residing in the same home (regardless of funding source), the total number of units of shared Personal Assistance shall be apportioned based on an assessment of individual need and the apportioned amount included in the ISP for each waiver participant, as applicable. Only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported. Documentation of service delivery must be kept for each person supported and shall reflect the total number of shared units of service provided, and the tasks performed/assistance provided for that individual.

Personal Assistance is often delivered in the place of residence of the person supported; however, it may be provided outside the person supported home in community-based settings where the Personal Assistance provider accompanies the person supported to perform tasks and functions in accordance with the approved service definition and as specified in the person-centered ISP. Personal Assistance does not include routine provision of Personal Assistance services in an area outside the person's local community of residence. On an infrequent and exceptional basis and in accordance with the approved person-centered ISP, Personal Assistance services may be provided in an area outside the person's local community of residence.

Personal Assistance may be provided in the home or community; however, it shall not be provided in schools for school-age children, to replace personal assistance or similar services required to be covered by schools, to transport or otherwise take children to or from school, or to replace services available through the Medicaid State Plan/TennCare Program. Personal Assistance services shall not be provided in the home of the Personal Assistant, except (1) when the person supported lives in the home with the Personal Assistant or (2) on an infrequent and exceptional basis when the person supported is attending a special event (e.g., a party) that is held in the home of the Personal Assistant. Services provided in the Personal Assistant's home must be specified and in accordance with the approved person-centered ISP.

Personal Assistance may be provided during the day or night, as specified in the person-centered ISP. A person supported who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Individuals receiving Personal Assistance services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

Personal Assistant Services shall not be provided during the same time period that the person supported is receiving Day Services, Respite Services, services under a 504 Plan or Individual Education Program (IEP), is being home schooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Personal Assistance shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home) when the facility's licensure category requires the provision of personal assistance or personal care services.

Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the person supported. The Personal Assistant shall not be the spouse of a person supported and shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Personal Assistance provided by such individuals. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

Family members are required to implement services as specified in the person-centered ISP. Reimbursement to family members shall be limited to forty hours per week per family member. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

The unit of reimbursement for Personal Assistance services shall be 15 minutes. The Personal Assistance provider is not obligated to provide transportation for the person supported as part of the Personal Assistance service; however, a Personal Assistance provider who is also an Individual Transportation Services provider may bill for Individual Transportation Services for transport of the person supported into the community.

Personal Assistance may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be subject to the same monthly limitation as Personal Assistance services provided in-state and in addition, are limited to a maximum of 14 days of service per person supported per waiver program year (calendar year), regardless of the number of hours of service provided each day.

b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to

assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).

c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver.

The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Applicable limits, if any, on the amount, frequency, or duration of this service: Personal Assistance services shall be limited to a maximum of 860 units (215 hours) per waiver participant per month. Out of state Personal Assistance services are subject to the same monthly limitation, and in addition, are limited to a maximum of 14 days per waiver participant per waiver program year (i.e. calendar year).

Title: Personal Emergency Response System

Service Definition (Scope):

A Personal Emergency Response System shall mean a stationary or portable electronic device used in the place of residence of the person supported which enables the person supported to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

A Personal Emergency Response System shall consist of installation and testing of the Personal Emergency Response System as well as monthly monitoring performed by a response center.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Monitoring is limited to 1 unit/month (12 units/calendar year) maximum.

Title: Physical Therapy

Service Definition (Scope):

Physical therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations related to ambulation and mobility; and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Physical Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist. Physical Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care.

Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted). Physical Therapy shall be provided in accordance with a treatment plan developed by a licensed physical therapist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Physical Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Physical Therapy services shall require documentation of reassessment of the condition of the person supported and continuing progress of the person supported toward meeting the goals and objectives.

Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language, and Hearing Services; Nutrition Services, Orientation and Mobility Services for Impaired Vision; or Behavior Services, unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently. Physical Therapy is not intended to replace services that would normally be provided by direct care staff.

Physical Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Physical Therapy shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSTDT benefits).

The unit of reimbursement for a Physical Therapy assessment with plan development shall be per day. The unit of reimbursement for other Physical Therapy services shall be per 15 minutes. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Physical Therapy services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Physical Therapy unless provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Reimbursement limits:

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

Title: Residential Habilitation

Service Definition (Scope):

Residential Habilitation shall mean a type of residential service selected by the person supported, offering individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a community-based setting and which supports each resident's independence and full integration into the community, and ensures each resident's choice and rights. Residential Habilitation services shall be provided in a dwelling which may be rented, leased, or owned by the Residential Habilitation provider, and shall comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the person supported. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation, household chores) essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community.

Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Residential Habilitation may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other noncomplex health maintenance tasks, as permitted by State law.

The Residential Habilitation provider shall oversee the person's health care needs. The Residential Habilitation dwelling shall be licensed by the State of Tennessee. A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so. Individuals receiving Residential Habilitation services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted pursuant to state

licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work. A person supported who is receiving Residential Habilitation shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Residential Habilitation provider). With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, and in accordance with TennCare protocol, transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such.

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

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

Residential Habilitation may be provided out-of-state under the following circumstances:

- a. Out-of-state services shall be limited to a maximum of 14 days per person supported per waiver program year (i.e. calendar year).
- b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
- c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable)

to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out -of- state services shall not be reimbursed through the waiver.

The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Respite**Service Definition (Scope):**

Respite shall mean services provided to a person supported when unpaid caregivers are absent or need relief from routine caregiving responsibilities. Respite may be provided in the person's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/IID, in a home operated by a licensed residential provider, in a licensed respite care facility, or in the home of an approved respite provider. The Respite provider may also accompany the person on short outings for exercise, recreation, shopping or other purposes while providing respite care.

Reimbursement for Respite shall not include payment for Respite provided by the spouse of a person supported or family member or relative (whether by birth or marriage) who resides with the person supported in the home. The Respite provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Respite provided by such individuals. Reimbursement for Respite shall not include payment for Respite provided by any individual who has been appointed as the conservator for the person supported unless so permitted in the Order for Conservatorship. Family members who provide Respite must meet the same standards as providers who are unrelated to the person supported, including implementing services as specified in the individual support plan (ISP).

When less than 8 hours of respite services is needed in a day, the unit of reimbursement shall be per 15 minutes. When 8 hours or more of respite services are needed in a day, the unit of reimbursement shall be per day. Level 1 per day reimbursement shall be for persons requiring at least 8 hours, but less than 16 hours of respite services in a day. Level 2 per day reimbursement shall be for persons requiring at least 16 and up to 24 hours of respite services in a day, but no awake overnight direct support staff. Level 3 per day reimbursement shall be for persons requiring 24 hour respite services, including awake overnight direct support staff. Respite shall be limited to a maximum of 30 days per person supported per waiver program year (i.e. calendar year).

Family members are required to implement services as specified in the ISP. Reimbursement to family members shall be limited to forty hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person's Circle of Support shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program. Providers who receive the per diem reimbursement rate for Respite shall be responsible for the cost of any Day Services needed while the person is receiving Respite services.

Respite Services shall not be provided during the same time period that the person supported is receiving Personal Assistance Services, Day Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof.

Applicable limits, if any, on the amount, frequency, or duration of this service: Respite shall be limited to a maximum of 30 days per person supported per calendar year.

Title: Semi-Independent Living Services

Service Definition (Scope):

Semi-Independent Living Services (SILS) shall mean services selected by the person supported that include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene, interpersonal and social skills building, and other activities needed to maintain and improve the capacity of an individual with an intellectual disability to live in the community, and which supports the person's independence and full integration into the community, ensures the person's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual's specific assessed need and set forth in the person-centered Individual Support Plan (ISP). The service also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The SILS provider shall oversee the health care needs of the person supported.

This service is appropriate for people who need intermittent or limited support to remain in their own home and do not require staff that lives on-site. However, access to emergency supports as needed from the provider on a 24/7 basis is an essential component of this residential service and is what differentiates it from Personal Assistance services. Individuals receiving SILS may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home. No more than 3 persons receiving services will be permitted per residence.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

The Circle of Support must consider the person's level of independence and safety prior to establishing a semi-independent living arrangement. Safety considerations must be reviewed at least annually (and more often should a change of needs or circumstances warrant).

Consideration regarding the use of a Personal Emergency Response System should be given when appropriate. The ISP must reflect the routine supports that will be provided by residential

staff. The person may choose to live with one or two other persons supported and share expenses or to live alone as long as sufficient financial resources are available to do so. Reimbursement for SILS shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person(s) supported and other residents in the home (if applicable). A person who is receiving SILS shall not be eligible to receive Personal Assistance, Respite or Transportation as separate services. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of SILS and shall be included in the reimbursement rate for such.

The SILS provider shall not own the person's place of residence or be a co-signer of a lease on the person's place of residence unless the provider signs a written agreement with the person that states that the person will not be required to move if the primary reason is because the person desires to change to a different provider. The SILS provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person to move if the person desires to change to a different provider.

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

On a case-by-case basis, the DIDD Commissioner or designee may authorize SILS for a person supported who resides with his or her spouse and or minor children. SILS shall not be provided out-of-state. A minimum of two face-to-face direct service visits in the home per week are required for each person receiving SILS. However, providers delivering this service are required to implement provisions for availability of provider staff on a 24 hour basis in case emergency supports are needed. SILS providers are required to be licensed as Mental Retardation (i.e., Intellectual Disabilities) Semi-Independent Living Providers.

For individuals who are transitioning from a 24-hour residential waiver service supports into SILS and need additional hours of support during the transition period, providers will be reimbursed at a transition period rate, per the waiver max fee schedule, for a period of no more than 30 days from the date of transition.

For persons supported successfully transitioned from a 24-hour residential waiver service into Semi-Independent Living, a one-time per person “Transition to Independent Living Payment” will be made to the provider after the person supported has spent 6 consecutive months in SIL, so long as the person is still in SIL at the time of billing and is expected to continue living successfully in this setting. The “Transition to Independent Living Payment” will not count against a person’s individual cost neutrality cap, but will be included in all federally required demonstrations of waiver cost neutrality.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Specialized Medical Equipment and Supplies and Assistive Technology

Service Definition (Scope):

Specialized Medical Equipment and Supplies and Assistive Technology shall only mean the following:

a. An assistive device or adaptive aid or control designed for individuals with special functional needs which:

(1) Increases the ability to perform activities of daily living (e.g., adaptive eating utensils and dishware; an adaptive toothbrush); or

(2) Increases the ability to communicate with others (e.g., a hearing aid; an augmentative alternative communication device or system; an adaptive phone for individual with visual or hearing impairments); or

(3) Increases the ability to perceive or control the environment within the home (e.g., a smoke alarm with a vibrating pad or flashing light); and

b. A gait trainer; and

c. A sidelyer or similar positioning device; positioning wedges or rolls or similar positioning items; and

d. Supplies necessary for the proper functioning of specialized medical equipment or assistive technology covered within the scope of this waiver definition; and

e. Repair of specialized medical equipment or assistive technology devices covered within the scope of this waiver definition when the repair is not covered by warranty and when it is substantially less expensive to repair the equipment or device than replace it.

Specialized Medical Equipment, Supplies, and Assistive technology shall be medically necessary and shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist). The following items are excluded from coverage:

a. Items not of direct medical or remedial benefit to the person supported;

b. Items covered by the Medicaid State Plan/TennCare Program;

c. Hearing aids and augmentative alternative communication systems for children under age 21 years;

d. Eyeglasses, frames, and lenses;

- e. Elevators, stairway lifts, stair glides, platform lifts, stair-climbing devices, electric powered recliners, elevating seats, and lift chairs;
- f. Sensory processing/sensory integration equipment or other items used in sensory integration therapy (e.g., ankle weights, weighted vests or blankets, sensory/therapy balls, swings, vibrators, floor mats, balance boards, brushes, trampolines);
- g. Carpets, rugs, flooring, floor pads and mats; curtains, drapes, and window treatments; furniture, lamps, and lighting;
- h. Beds, mattresses, bedding, and overbed tables;
- i. Air conditioning systems or units, heating systems or units; water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
- j. Electrical generators, electrical service, or emergency electrical backup systems;
- k. Adaptive devices for use with items specifically excluded by this waiver definition;
- l. Recreational or exercise equipment and adaptive devices for such; adaptive tricycles;
- m. Toys, toy equipment, and adaptive devices for toys (e.g., flash switches);
- n. Radios, televisions, or related electronic audiovisual equipment (e.g., DVD players); telephone, television, or internet service; and equipment or items for education, training, or entertainment purposes;
- o. Personal computers; printers, monitors, scanners, and other computer-related hardware and software (excluding equipment designed specifically and primarily to be used as an augmentative alternative communication systems for adults);
- p. Orthotics;
- q. Stethoscopes or blood pressure cuffs;
- r. Clothing;
- s. Diapers and other incontinence supplies;
- t. Food, food supplements, food substitutes (including formulas), and thickening agents;

- u. Prescription and over-the-counter medications; vitamins, minerals, and nutritional supplements;
- v. Swimming pools, hot tubs, whirlpools and whirlpool equipment, and health club memberships;
- w. Lifting and tracking systems for transfer of persons supported;
- x. Supplies other than those supplies specifically required for the proper functioning of specialized medical equipment or assistive technology devices that are covered within the scope of this definition;
- y. Duplicate items of specialized medical equipment or assistive technology, excluding adaptive eating utensils and dishware, to provide the person supported with a backup or spare;
- z. Repair of equipment covered by warranty;
- aa. Physical modification of the interior or exterior of a place of residence; and
- bb. Physical modification of a motor vehicle or motor vehicle parts and services, including adaptive devices to facilitate driving.

Specialized Medical Equipment, Supplies and Assistive Technology is not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the Department's policy on submission of bids. If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for the Specialized Medical Equipment, Supplies, and Assistive Technology or the request will be denied. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of \$10,000 per person supported per 2 waiver program years (calendar years). The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of \$10,000 per service recipient per 2 waiver program years (i.e. calendar years).

Title: Speech, Language, and Hearing Services

Service Definition (Scope):

Speech, Language, and Hearing Services shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure which are provided to assess and treat functional limitations involving speech, language, or chewing/swallowing and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Speech, Language, and Hearing Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

Services must be provided by a licensed speech language pathologist or by a licensed audiologist. Speech, Language, and Hearing Services must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Speech, Language, and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language, and Hearing assessments (i.e., assess and treat orders are not accepted).

Speech, Language, and Hearing Services shall be provided in accordance with a treatment plan developed by a licensed speech language pathologist or a licensed audiologist based on a comprehensive assessment of the needs of the person supported, and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Speech, Language, and Hearing Services to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Speech, Language, and Hearing Services shall require documentation of reassessment of the person's condition and continuing progress of the person supported toward meeting the goals and objectives.

Speech, Language, and Hearing Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the person's record of medical justification for the two services to be provided concurrently. Speech, Language, and Hearing Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Speech, Language, and Hearing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSTDT benefits).

The unit of reimbursement for a Speech, Language, and Hearing Services assessment with plan development shall be per day. The unit of reimbursement for other Speech, Language, and Hearing Services shall be per 15 minutes. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider.

Speech, Language, and Hearing Services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Speech, Language, and Hearing Services assessments shall not be billed on the same day with other Speech, Language, and Hearing Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Speech, Language, and Hearing Services unless provided by a licensed speech language pathologist or by a licensed audiologist.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Reimbursement limits:

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

Title: Support Coordination

Service Definition (Scope):

Support Coordination shall mean the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities to develop personal relationships, participate in their community, increase control over their own lives, and develop the skills and abilities needed to achieve these goals, person supported as specified in person supported the individual's person centered Individual Support Plan (ISP). Support Coordination shall be provided in a manner that comports fully with standards applicable to person-centered planning for services delivered under Section 1915(c) of the Social Security Act.

Specific tasks performed by the Support Coordination provider shall include, but are not limited to general education about the waiver program, including individual rights and responsibilities; providing necessary information and support to the individual to support his/her direction of the person-centered planning process to the maximum extent desired and possible; initial and ongoing assessment of the individual's strengths and needs; identification of what is important to the individual, including preferences for the delivery of services and supports; actual development, ongoing evaluation, and updates to the ISP as needed or upon request of the individual; coordination with the individual's health care providers and MCO(s), as applicable, to ensure timely access to and receipt of needed physical and behavioral health services; supporting the individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS; specific documentation of any modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes prescribed in federal and state regulation and protocol; and monitoring implementation of the ISP and initiating updates as needed and addressing concerns which may include reporting to management level staff within the provider agency; or reporting to DIDD when resolution is not achieved and the ISP is not being implemented. The ISC will provide the individual with information about self-advocacy groups and self-determination opportunities and assist in securing needed transportation supports for these opportunities when specified in the ISP or upon request of the individual.

Support Coordination contacts shall include at least one face-to-face contact with the person supported per calendar month. If the person supported receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the person supported in the place of

residence of the person supported each quarter (i.e. once every 3 months). If a person supported will need more frequent contacts from the ISC on an ongoing basis, such frequency should be specified in the ISP and Support Coordination shall be provided in accordance with the person's needs as specified in the ISP. The Support Coordination provider shall initiate and oversee at least annual reassessment of the individual's level of care eligibility, and initial and at least annual assessment of the individual's experience to confirm that that the setting in which the individual is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Supported Living

Service Definition (Scope):

Supported Living shall mean a type of residential service selected by the person supported having individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a home that is owned or leased by the residents and which supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation (excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Supported Living may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

The Supported Living provider shall oversee the health care needs of the person supported. The Supported Living provider shall not own the place of residence of the person supported or be a co-signer of a lease on the place of residence of the person supported unless the Supported Living provider signs a written agreement with the person supported that states that the person supported will not be required to move if the primary reason is because the person supported desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person supported to move if the Supported Living provider changes. The person supported (or the parent, guardian, or conservator acting on behalf of the person supported) shall have a voice in

choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.

A Supported Living home shall have no more than 3 residents including the person supported. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must pass a home inspection approved by the State Medicaid Agency. The Supported Living provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not receiving Day Services, is not otherwise engaged with natural supports, or is not at school or work. Thus, a person supported who is receiving Supported Living shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Supported Living provider).

Supported Living shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)). Supported Living shall not be provided in a home where a person supported lives with family members unless such family members also receive Supported Living services, or by special exception when the family member is a minor child living with a parent receiving services or spouse of a person receiving services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

In Supported Living companion model, family and friends of the companion staff may only reside in the home of the person supported when approved by the person supported or his/her conservator. Such approval shall be documented in the person-centered ISP. Individuals receiving Supported Living services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

Supported Living shall not be covered for persons supported under age 18 years. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such.

Reimbursement for Supported Living shall not include payment for Supported Living provided by the spouse of a person supported. The Supported Living provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the

relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Supported Living provided by such individuals.

Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the person supported and who provides services to the person supported in the home of the person supported. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported, other residents in the home, and (as applicable) live-in or other caregivers. For Supported Living services in a companion model home, all U.S. Department of Labor, Wage and Hour Division rules shall be applied to live-in caregivers.

Supported Living may be provided out-of-state under the following circumstances:

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

The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Transitional Case Management

Service Definition (Scope):

Transitional Case Management shall mean case management services provided for the purpose of community transition of a Medicaid eligible person residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other institutional setting who has been determined to qualify for HCBS waiver services upon discharge during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver.

Transitional Case Management shall assist the person supported in identifying, selecting, and obtaining both paid services and natural supports to enhance the independence, integration in the community, and productivity of the person supported, as specified in the transitional plan of care.

Transitional Case Management shall be person-centered and shall include, but not be limited to, ongoing assessment of the strengths and needs of the person supported; development, evaluation, and revision of the transitional plan of care; assistance with the selection of service providers; provision of general education about the waiver program, including person supported rights and responsibilities; and monitoring implementation of the transitional plan of care. Transitional case management shall include at least one face-to-face contact with the person supported per calendar month. The date the person leaves the ICF/IID or other institutional setting and is enrolled in the waiver shall be the date of service for billing purposes.

Applicable limits, if any, on the amount, frequency, or duration of this service:

Limited to the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver.