

Waiver TN.0357.R03.00

Program Title: Comprehensive Aggregate Cap (or "CAC") Waiver

Type of Request: renewal - 5 years

Original Base Waiver Number: TN 0357

Waiver Type: Regular Waiver

Proposed Effective Date: Jan 1, 2015

Application Status: SUBMITTED

Draft ID: TN.015.03.00

Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

This is a renewal application for waiver #0357, currently titled the Home and Community-Based Services Waiver for Persons with Mental Retardation. Tennessee proposes, effective January 1, 2015, to call this waiver the Comprehensive Aggregate Cap (or "CAC") waiver.

In addition to the renewal of this waiver with a new name, amendments encompassed within the renewal application intend to:

1) Modify service definitions and other applicable waiver sections in order to ensure compliance with the Final Rule released by the Centers for Medicare and Medicaid Services (CMS) on HCBS Setting and Person Centered Planning requirements, and to clarify Family Model Residential Services as it relates to compliance with the Department of Labor's Final Rule pertaining to the Fair Labor Standards Act. Tennessee believes it is critical that the objectives of the HCBS Setting and Person-Centered Planning rule are embedded within waiver service definitions and waiver processes in order to appropriately set expectations for all HCBS providers and to support and indeed, require, the kind of culture shift necessary for these objectives to be realized in the lives of individuals receiving support.

2) Modify the Quality Management Strategy in order to reflect CMS changes to waiver Quality Monitoring assurances and sub-assurances, including adding, modifying, or deleting specific performance measures in the waiver application. (The State will continue to monitor performance and assure compliance with waiver requirements, where applicable and/or deemed important.) Changes related to annual reporting, per the CMS Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, released in March 2014, are incorporated throughout. Tennessee would also like to propose to consolidate reporting across the state's three 1915(c) waivers (0128, 0427, 0357) for the Qualified Providers assurance area, per the option offered in the Modifications stating, "...when waivers are managed and monitored similarly, it is expected that discovery and improvement activities would be the same, and that the state will achieve some administrative efficiencies by consolidating quality improvement activities. In addition, this holistic measure will ensure that the system for the waivers is responsive to the needs of all individuals served. CMS may accept a consolidated evidence report for multiple waivers when they meet certain conditions" (page 5 of the guidance document, (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By->

Topics/Waivers/Downloads/3-CMCS-quality-memo-narrative.pdf). The reason Tennessee proposes to consolidate reporting for the QP assurance is because our provider network services across all three waivers. Therefore, when there are findings in the QP assurance area, they are applicable (thus, the same compliance rates) across all three waivers. We believe that it is still valuable to measure performance separately across the 3 waivers for the other assurance areas because there may be important variances and will thus continue reporting performance for the state's three 1915(c) waivers (0128, 0427, 0357) separately in all assurance areas except for the Qualified Provider (QP) assurance.

3) Add Semi-Independent Living as a service and incorporate additional flexibilities and improvements into certain service definitions as recommended by stakeholders through an extensive stakeholder input process. Planned modifications include allowing people receiving different kinds of Medicaid-reimbursed HCBS—primarily residential services—to live together in the same homes, offering more choice and autonomy in living arrangements; allowing a single Personal Assistant or Nurse to provide services to more than one individual at the same time so long as the individuals' needs can be safely met; clarification regarding the provision of non-nursing assistance by a licensed nurse when nursing services are authorized for skilled nursing needs; and flexibility in the hours that Employment and Day Services are provided in order to support goals specified in the person-centered individual support plan.

4) Consolidate into a single Section 1915(c) waiver the group of individuals with intellectual disabilities who are former members of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), current members of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), and individuals transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver. These are individuals who have been institutionalized in a public institution, are part of a certified class because they were determined to be at risk of placement in a public institution, or have significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would continue to require placement in a Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Transition of individuals from the Statewide waiver identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver upon its renewal will help ensure continuity of current HCBS and supports, and minimize the potential for disruption that could negatively impact individuals receiving support.

- o The vision benefit will be eliminated in the CAC Waiver in order to better align benefits across the two programs; however, utilization of this benefit has been minimal, such that no significant negative impact is anticipated.

- o An increase in the number of unduplicated participants will be requested to accommodate these changes, and to reserve capacity for institutionalized former members of the certified class in Arlington or current members of the certified class in Clover Bottom who may subsequently elect to transition to HCBS. Except for reserve capacity, no additional individuals will be enrolled into the CAC Waiver, and all vacated "slots" will be returned via an amendment to reduce unduplicated participants as individuals leave the program.

Appendix J of the renewal application reflects revised cost neutrality projections based on the changes identified above.

These changes are part of a more comprehensive restructure of the service delivery system in Tennessee that will allow Tennessee to provide services to individuals with intellectual disabilities more

cost-effectively, and to ultimately be able to serve more people with intellectual disabilities (ID), as well as people with other developmental disabilities (DD), as set forth in a Concept Paper available at <https://tn.gov/assets/entities/tenncare/attachments/ConceptPaper.pdf>.

Brief Waiver Description

Brief Waiver Description. In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Comprehensive Aggregate Cap (CAC) Waiver serves individuals with intellectual disabilities who are former members of the certified class in the *United States vs. the State of Tennessee, et al.* (Arlington Developmental Center), current members of the certified class in the *United States vs. the State of Tennessee, et al.* (Clover Bottom Developmental Center), and individuals transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver. These are individuals who have been institutionalized in a public institution, are part of a certified class because they were determined to be at risk of placement in a public institution, or have significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The CAC Waiver offers a continuum of services that are selected by each individual pursuant to a person-centered planning process and support each person's independence and full integration into the community, including opportunities to seek employment and work in competitive integrated settings and engage in community life. Services are delivered in a manner which ensures each individual's rights of privacy, dignity, respect and freedom from coercion and restraint; optimizes individual initiative, autonomy, and independence in making life choices; and are delivered 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 Individual Support Plan.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Tennessee Home and Community Based Services Settings Rule

Transition Plan

Tennessee's State Medicaid Agency (SMA), the Bureau of TennCare (TennCare) submits this proposed Transition Plan in accordance with requirements set forth in the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) Settings Rule released on January 16, 2014.

In preparation for development of the state's proposed Transition Plan, TennCare completed certain activities believed to be pertinent to the development of the Transition Plan. Those activities are detailed below. Detailed Provider Self-Assessment and Individual Experience tools and the Assessment Worksheet, including instructions with timelines, will be submitted separately to the CMS regional project officer.

Section 1: Transition Plan Development and Public Input Activities (Forms of Public Notice)

1) Provider information meetings

a) Invitations were posted on the TennCare website and distributed through provider and advocacy organizations, the Department of Intellectual and Developmental Disabilities (DIDD) and contracted Managed Care Organizations (MCOs). They will be submitted separately to the CMS regional project officer.

b) Seven separate meetings were held across the state between July 8-24, 2014.

c) 628 attendees in total

d) Power point presentation was posted on the TennCare website on July 25, 2014 and submitted separately to the CMS regional project officer.

2) Consumer and family information materials and meetings

a) Consumer/family friendly materials were developed with input from provider and advocacy organizations.

b) Materials were posted on the TennCare website and distributed through provider and advocacy organizations, DIDD and MCOs.

c) TennCare hosted 2 open forum conference calls to educate consumers and families on the HCBS Settings Rule and the importance of their public input.

i. There were a total of 251 distinct phone numbers that accessed the calls, but since there were several participants who were gathered in groups, the actual number of participants is unknown, but greater than the number represented by distinct phone numbers.

ii. HCBS providers participated in these calls as well as consumers and families.

d) Some providers held family meetings as well.

e) Copies of these materials were submitted separately to the CMS regional project officer.

3) State posting of draft transition plan and assessment tools for public comment

a) All Transition Plan and Assessment Tool documents were posted at:

<https://tn.gov/tenncare/topic/transition-plan-documents-for-new-federal-home-and-community-based-services>. Individuals could provide comments online through the website, via the US postal service, or by emailing program staff directly.

b) The comment period extended from July 25, 2014 – September 19, 2014 as an interactive, working time between the state, providers, advocates, consumers and families. TennCare updated documents based on comments received and reposted the documents to the TennCare website as updated drafts.

i. The Transition Plan was revised based on:

1. Public comments received regarding timelines and assessment activities; and
2. Feedback received from CMS, including removal of Person-Centered Planning (PCP) components.
3. The proposed Transition Plan was revised and reposted on September 18, 2014.

c) Documents were finalized (with any additional comments received), posted and entered into CMS web portal with waiver submission October 1, 2014.

d) Cover letter, assessment tools and assessment tools instructions were submitted separately to the CMS regional project officer.

e) The final version of the Transition Plan submitted to CMS was posted on the TennCare website.

Section 2: Transition Plan Components

Part A: SMA Self-Assessment and Remediation

1) SMA self-assessment process: Ongoing – February 28, 2015

a. The state has initiated ongoing internal strategy meetings to prepare for and begin assessing all rules, regulations, policies, protocols, practices and contracts.

b. The state will develop and implement strategies for consumer and family, provider, advocate, and other stakeholder input into the self-assessment of state standards, requirements and practices.

c. Components of the SMA Self-Assessment shall include, at a minimum, the following:

i. HCBS definitions and provider qualifications: Proposed changes to waiver definitions are included in waiver renewal applications and amendments. Any subsequent changes identified will be submitted as waiver amendments.

ii. State law: The SMA will work in collaboration with DIDD as it relates to Title 33. Statutory revisions (including authority to revise licensure and other rules, as applicable) will be submitted during the upcoming legislative session. Tennessee's legislative session is January – April/May each year. State regulations: Rules requiring modification may include those that are under the authority of another state department. In addition to promulgating revised regulations under its own purview, as determined to be appropriate, the SMA will provide appropriate education and explanation to other

state departments regarding need for any rule revisions, which the SMA will formally request in writing, in order to allow the state to come into compliance as applicable. Proposed legislation in the upcoming session will provide statutory obligation and authority to make such rule revisions.

- iii. Policies, protocols, and practices (including Quality Management practices)
- iv. Training requirements
- v. Contracts, rate methodology, and billing practices: This will include contracts/Interagency Agreements the SMA currently holds with DIDD and the MCOs.
- vi. Information Systems
- vii. Specific timelines and milestones for achieving compliance with the new federal rules will be established as needed changes are identified, and included in an amendment to the State Transition Plan.

Part B. Contracted Entity Self-Assessment and Remediation

- 2) Contracted entity self-assessment process: October 1, 2014 – March 31, 2015
 - a. The DIDD and MCOs will be required to review all policies, procedures and practices (including Quality Management practices), training requirements, contracts, billing practices, person-centered planning requirements and documentation, and information systems to determine their compliance with the HCBS Settings Rule. Each entity will be required to submit its assessment along with evidence of compliance to the SMA. Each entity will also be required to identify any modifications needed to achieve compliance with the HCBS Settings Rule. The SMA will review each entity's self-assessment and evidence of compliance to ensure that all aspects of the system are congruent with CMS expectations and will allow the State to operate HCBS programs in a manner which comports with the HCBS Settings Rule. The SMA will request any additional information needed to assess compliance. Any changes needed to achieve compliance will be incorporated in an amendment to the State Transition Plan, including specific timeframes and milestones.
 - b. All revisions to policies, procedures, training requirements, etc. needed to achieve compliance with the new Rule will be submitted to the SMA for review and approval, and implementation will be tracked by the State in accordance with approved timeframes.
 - c. Upon approval, final versions will be completed and distributed to providers.
 - d. Provider education/training will be conducted as appropriate. All education and training materials will be led by or reviewed and approved by the SMA.

e. Specific to DIDD, in instances where a change in rule or policy requires a public comment period, time lines will be adjusted accordingly to accommodate time needed to process and respond to public input and incorporate such comments into document revisions.

Part C. Provider Self-Assessment and Remediation

3) Provider self-assessment process: October 15, 2014 – March 31, 2015

a. The State will conduct statewide provider education and training sessions on how to complete the Provider Self-Assessment Tool. These training sessions will be conducted between October 15, 2014 – November 15, 2014.

b. Providers will receive the applicable Provider Self-Assessment Tool with the Assessment Tool instructions and time lines. At a minimum, all HCBS residential, employment and day program, and PA providers will be required to complete a self-assessment.

c. Providers will be required to include persons served, family members/representatives, advocates, and other stakeholders in their assessment process.

d. Providers will be required to include in their self-assessment a description of their self-assessment process, including participation of the aforementioned persons.

e. Providers will submit their respective Self-Assessment along with specific evidence of compliance for further review by the SMA or its designee (DIDD or MCOs). Additional evidence may be requested or further reviews conducted as needed to further assess and validate compliance with these rules.

f. Providers who self-report or are assessed to be non-compliant with the HCBS Settings Rule will be required to submit a Provider Transition Plan identifying the area(s) of non-compliance and describing their proposed plan for coming into compliance along with associated time lines. Information regarding Provider Transition Plans and specific timelines for achieving compliance will be incorporated in an amendment to the State Transition Plan.

g. All completed and validated Provider Transition Plans will be reviewed and approved by the DIDD or MCO as applicable, and implementation will be monitored based on approved timeframes, with oversight by the SMA.

h. Providers needing assistance to achieve compliance may request such assistance from the entity with whom they are contracted (DIDD or MCO), another (compliant) provider of the same service type, and/or consumers and family members or advocates.

i. Providers assessed to be unwilling or unable to come into compliance, will be required to cooperate with transition assistance to ensure all individuals served are transitioned to an appropriate provider type, maintaining continuity of services.

i. The SMA, in conjunction with DIDD or the MCOs, as applicable, will oversee all necessary transition processes:

1. A minimum of 30 days notice will be given to all persons needing to transition between providers. More notice may be granted in instances when residential services are being secured.

2. A description of the process and choice of appropriate providers will be included with each notice. The person's ISC, case manager or care coordinator, as appropriate, will conduct a face to face visit as soon as possible to discuss the transition process and ensure they understand any applicable due process rights.

Part E. Individual Experience Assessment

4) Individual Experience Assessment process: November 1, 2014 – October 31, 2015

a. Each individual's ISC, case manager or care coordinator, as applicable, will assist the individual and his/her family member/representative, as appropriate, in completing an initial Individual Experience Assessment. Service provider staff may participate as requested by the individual and his/her family member/representative.

b. Such assessments will be conducted, beginning November 1, 2014 during the individual's annual plan of care review, or sooner if an amendment or plan review is conducted prior to the annual review.

c. This initial assessment period will be ongoing for one year to allow each ISC, case manager and care coordinator the opportunity to conduct the Individual Experience Assessment while completing a scheduled annual review or needed amendment.

d. For provider owned/controlled settings, any proposed modification of requirements set forth in the HCBS Settings Rule for the individual shall be reviewed to confirm that:

i. There is a specific individualized assessed need for such modifications;

ii. Prior interventions and supports including less intrusive methods have been tried and demonstrated to be unsuccessful;

iii. The proposed modification is appropriate based on the specific need identified; and

iv. The proposed modification, including interventions and support will not cause harm to the individual.

- e. Each of the above items (i.-iv.) shall be documented in the person-centered plan of care, along with:
- i. The method of collecting data on an ongoing basis to measure the effectiveness of the modification; and
 - ii. A specific time limit for periodic review of the data and the effectiveness of the modification to ensure it continues to be appropriate.
- f. The individual shall provide informed consent of the proposed modification.
- g. If a modification to the HCBS Settings Rule is determined to be inappropriate based on the person's individualized needs (and in accordance with the requirements above), the area identified as non-compliant will trigger a new assessment of the provider, as applicable, and a Transition Plan developed by the provider to address any issues of non-compliance will be submitted to the contracting entity for review, approval and monitoring of implementation.

Part F. Achieving Initial Compliance

No later than December 31, 2015, upon review and validation of State, contracted entity, and provider self-assessments, the State will submit an amendment to the State Transition Plan with specific remediation activities and milestones for achieving compliance with the HCBS Settings Rule.

For providers needing assistance to come into compliance the state proposes to implement the following strategies:

- Facilitate focus groups of non-compliant and compliant providers who can talk through provider specific issues and problem-solve how to achieve compliance together. Participation will be voluntary and can include consumers and family members who may aid in the problem solving process.
- Provide one-on-one technical assistance (TA) (TA will be provided upon request by the DIDD, MCO and or SMA as appropriate)

Part G. Assuring Ongoing Compliance

Once overall compliance is achieved, strategies to ensure ongoing compliance will include:

- Incorporating the Individual Experience Assessment (as described above) into all initial and annual plan of care reviews

- Quality assurance methodologies will incorporate monitoring performance measures that ensure compliance with HCBS Settings and PCP Rules
- Consumer/family satisfaction surveys
- The State will also explore the use of Core Indicators data to support its ongoing compliance monitoring efforts.

Appendix A: Waiver Administration and Operation

State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency

Department of Intellectual and Developmental Disabilities (DIDD)

Appendix A: Waiver Administration and Operation

Oversight of Performance.

Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Comprehensive Aggregate Cap (“CAC”) Waiver is operated by the Department of Intellectual and Developmental Disabilities (DIDD) through an interagency agreement with the Bureau of TennCare, Department of Finance and Administration. The Tennessee Department of Finance and Administration is designated as the Single State Medicaid Agency for the State of Tennessee. The Bureau of TennCare is the state's medical assistance unit and is located within the Department of Finance and Administration's Division of Health Care Finance and Administration. The TennCare Director, who serves as a Deputy to the Commissioner of the Department of Finance and Administration and head of the Division of Health Care Finance and Administration, is the State Medicaid Director and exercises legal authority in the administration and supervision of the Medicaid State Plan and the TennCare 1115 Demonstration Waiver, and issues policies, rules and regulations on program matters. TennCare is accountable for

oversight of this waiver program and retains the responsibility for approval of policies and promulgation of rules governing this waiver.

DIDD is responsible for the operational management of the waiver on a day-to-day basis and is accountable to the State Medicaid agency which ensures that the waiver operates in accordance with federal waiver assurances. Responsibility is delegated to DIDD and monitored by TennCare for waiver enrollment, level of care reevaluations, development of the ISP, prior authorization of waiver services, enrollment of qualified providers, and certain quality assurance activities. TennCare exercises administrative authority and supervision of these functions through the interagency agreement which is reviewed on an annual basis to ensure that it accurately reflects expectations and incorporates any program changes implemented as a result of recent waiver amendments or changes in state or federal requirements. TennCare promulgates state waiver rules and approves all documents pertaining to daily operational management of the waiver prior to their issuance and implementation, including (but not limited to): all DIDD policies and procedures, Provider Manual revisions, provider rate changes, and mass communications to providers and persons supported.

In addition to ongoing informal communication processes, monthly meetings between TennCare and DIDD ensure adequate TennCare oversight. Monthly meetings include:

- The Interagency Executive and Senior Leadership Meeting: Executive and Senior leadership of TennCare and DIDD meet on at least a monthly basis to discuss issues pertaining to operation and oversight of this (and other) HCBS waiver program(s) for individuals with intellectual disabilities.
- The Policy Meeting: TennCare and DIDD staff review DIDD policies and stakeholder memorandums under development, including the status of those under review at TennCare; Provider Manual revisions; changes in TennCare rules and policy; and the status of waiver applications or amendments, as applicable. This forum is also used as a mechanism for DIDD to obtain TennCare policy interpretations and for TennCare to assign responsibility for CMS deliverables.
- The Statewide Continuous Quality Improvement Meeting: DIDD and TennCare LTSS Quality and Administration staff review identified data and reporting issues, as well as findings resulting from DIDD and TennCare Quality Assurance activities (e.g., targeted Reviews, utilization reviews, fiscal audits) and discuss appropriate corrective actions.
- The Abuse Registry Review Committee Meeting: A TennCare representative serves on the Abuse Registry Review Committee and participates in the review of substantiated allegations of abuse, neglect, and exploitation. The committee decides when individuals will be referred for placement on the Tennessee Department of Health Abuse Registry.
- The Statewide and Regional Planning and Policy Council Meetings: DIDD and TennCare staff participate in meetings with stakeholders including persons supported and their family members, a variety of provider representatives enrolled as waiver service providers (e.g., clinical service providers,

residential/day providers and/or support coordination providers), representatives from person supported and provider advocacy organizations, and other stakeholders. Planning and Policy Council members are routinely advised of expected changes in policy, provider requirements, and provider reimbursement; waiver application and amendment status; HCBS program expenditures and the state's budget situation; and other issues impacting service delivery and program operations. The Council makes recommendations to the State regarding program and policy improvements.

Appendix A: Waiver Administration and Operation

Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate

measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver for all persons except where approved reserved capacity is designated for specific regions or circumstances
- Compliance with HCB settings requirements and other **new** regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.1. Number and percentage of waiver policies/procedures developed by DIDD that were approved by TennCare prior to implementation. [Interagency Contract section A.1.b.] Percentage = number of waiver policies/procedures approved by TennCare prior to implementation / total number of waiver policies/procedures implemented.
a.i.7. Number and percentage of substantiated cases of abuse, neglect and exploitation that were appropriately and timely remediated by DIDD. [Interagency Contract section A.2.a.) Percentage = number of substantiated cases of abuse, neglect and exploitation appropriately and timely remediated / total number of substantiated cases of ANE.
a.i.4. # and % of Individual Support Plans that did not include outcomes, measureable action steps, or the things important to the participant that were appropriately and timely remediated by DIDD. [Interagency Contract section A.1.g & A.1.i] Percentage = number of deficient Individual Support Plans appropriately and timely remediated/ total # of deficient Individual Support Plans identified.
a.i.8. Number and percentage of inappropriate provider claims identified via post-payment review processes that were appropriately and timely remediated by DIDD. [Interagency Contract section A.2.b.] Percentage = number of inappropriate claims appropriately and timely remediated / total number of inappropriate claims identified via post-payment review processes.
a.i.2. Number and percentage of individual findings regarding level of care reevaluation that were appropriately and timely remediated by DIDD. [Interagency Contract section A.1.h.] Percentage =

Performance Measure
number of level of care reevaluation findings appropriately and timely remediated/ total number of level of care reevaluation findings identified.
a.i.3. Number and percentage of individual findings regarding provider (including staff) qualifications that were appropriately and timely remediated by DIDD. [Interagency Contract section A.1.n & A.2.a.(2)] Percentage = number of provider qualification issues appropriately and timely remediated/ total number of provider qualification issues identified.
a.i.6. # & % of waiver participants not offered choice (i.e., of waiver versus institutional services, of waiver services, and of qualified service providers) for whom remediation was appropriately and timely completed by DIDD. [Interagency Contract sec. A.1.d & A.2.d.(2)] % = # of participants not offered choice with appropriate and timely remediation/total # of participants not offered choice.

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

[blank]

Methods for Remediation/Fixing Individual Problems

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

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

may assess monetary sanctions against DIDD, require additional DIDD staff training, conduct additional monitoring and/or require the submission of additional data to ensure 100% compliance with this subassurance.

Performance Measure a.i.2. through a.i.8.: Issues requiring individual remediation will be discovered primarily through analysis of DIDD performance measure discovery data files and DIDD Quality Management Reports. TennCare will hold DIDD accountable for timely remediation of all individual issues identified. TennCare routinely monitors DIDD monthly remediation reports to determine if acceptable remedial activities have been completed. DIDD is notified monthly of any remediation determined unacceptable and is required to provide additional information and/or complete additional remediation activities until TennCare can determine that the issue has been resolved. DIDD is required to remediate all individual issues identified within a targeted time-frame of 30 calendar days. Remediation Reports contain data indicating the number of compliance issues for which remediation was completed within 30 calendar days.

Individual Remediation Data Aggregation: DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible DIDD staff and back-up staff are identified for each task. Designated DIDD Central Office staff compile the data collected and entered by regional and central office staff into DIDD databases to create data files that are posted for TennCare analysis and aggregation. In addition, DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Intellectual disability

1. Additional Criteria. The State further specifies its target group(s) as follows:

Enrollment is further limited to individuals who:

- a. Meet TennCare ICF/IID level of care criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PreAdmission Evaluation approved by TennCare;
- b. Have been assessed and found to have an intellectual disability manifested before eighteen 18 years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); and
- c. Have been identified by the state as a former member of the certified class in the United States vs. State of Tennessee, et al. (Arlington Developmental Center), a current member of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), or an individual transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because he or she was identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver.

Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):

- Not applicable. There is no maximum age limit

Appendix B: Participant Access and Eligibility

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

1. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit. The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

1. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	1923
Year 2	1923
Year 3	1923
Year 4	1923
Year 5	1923

2. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- The State does not limit the number of participants that it serves at any point in time during a waiver year.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

3. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- Not applicable. The state does not reserve capacity.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

4. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

5. **Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.

• **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry to the CAC Waiver is available only to Tennessee residents in the target population (including additional target criteria specified in Appendix B-1(b))who:

1. Meet Medicaid financial eligibility criteria in one of the specified eligibility groups;
2. Need the level of care provided in an Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) level of care criteria, as evidenced by TennCare approval of a Pre-Admission Evaluation (PAE); and
3. Meet all applicable enrollment requirements set forth in TennCare Rule Chapter 1200-13-1-.28, including a determination by DIDD that the individual's medical, behavioral and specialized services and support needs can be safely met through the Waiver, based on a pre-enrollment assessment; and a place of residence with an environment that is adequate to reasonably ensure the person's health, safety and welfare.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

1.
 1. **State Classification.** The State is a (*select one*):
 - §1634 State
 - SSI Criteria State

209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

No

Yes

2. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

SSI recipients

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. **The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**
- Yes. **The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

1. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

Allowance for the needs of the waiver participant (*select one*):

Other, Specify: 200% of the SSI/FBR

Allowance for the spouse only (*select one*):

- Not Applicable
-

Allowance for the family (*select one*):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard

Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

1. Health insurance premiums, deductibles and co-insurance charges
2. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
- The State does not establish reasonable limits.
- The State establishes the following reasonable limits

Deductions for any other medical services recognized under State law but not covered by Medicaid will be provided per contract of the providers usual and customary charges, billed charges, or 80% of the Medicare fee schedule. Deductions will be allowed only for services that are determined by the state to be medically necessary for the particular individual on whose behalf the services are being requested.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

4. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

1. Allowance for the personal needs of the waiver participant

(select one):

Other: 200% of the SSI-FBR

If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

1. Health insurance premiums, deductibles and co-insurance charges
2. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.

The State does not establish reasonable limits.

The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

1. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

1. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

2. Frequency of services. The State requires (select one):

- The provision of waiver services at least monthly
- Monthly monitoring of the individual when services are furnished on a less than monthly basis

Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency
- By the operating agency specified in Appendix A
- By an entity under contract with the Medicaid agency.
- Other

Specify:

1. The Bureau of TennCare, the State's Medical Assistance Unit, which is within the Department of Finance and Administration, is responsible for performing the initial level of care evaluations (PAEs).
2. The Department of Intellectual and Developmental Disabilities (DIDD) is responsible for the annual level of care reevaluation.

Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Physician (M.D. or D.O.) or Registered Nurse, licensed in the State of Tennessee

Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Initial Level of Care Criteria: The State's level of care criteria for the CAC Waiver specifies that the applicant must meet ICF/IID level of care criteria, as verified by approval of the PreAdmission Evaluation (PAE) for ICF/IID Care (the State's level of care assessment tool). Those criteria are as follows:

1. Have a diagnosis of intellectual disability manifested before eighteen (18) years of age; and

2. Require a program of specialized services for intellectual disability or related conditions provided under the supervision of a qualified intellectual disability professional (QIDP); and
3. Have a significant deficit or impairment in adaptive functioning in one of the following areas: communication, comprehension, behavior, or activities of daily living (e.g., toileting, bathing, eating, dressing/grooming, transfer, mobility).

Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Level of Care Criteria for Reevaluation: There are four level of care requirements that must be met for continued enrollment in the waiver during the reevaluation process. The person supported must:

1. Need the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/IID.
2. Require services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability.
3. Have a significant deficit in impairment in adaptive functioning involving communication, comprehension, behavior, or activities of daily living (i.e., toileting, bathing, eating, dressing/grooming, transfer, or mobility); and
4. Require a program of specialized supports and services provided under supervision of a Qualified Intellectual Disability Professional (QIDP).

Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months
- Every six months
- Every twelve months

Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Qualifications of professionals who conduct annual reevaluations are:

- Physician, either a D.O. or M.D.;
- Registered Nurse licensed in the State of Tennessee; or

- Qualified Intellectual Disabilities Professional (QIDP), as defined in 42 CFR 483.430(a)

Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (specify):

Each DIDD regional office tracks and monitors annual level of care reevaluations due dates through the DIDD Client Information Tracking System on a monthly basis to ensure timely receipt.

Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Initial Level of Care Evaluations: Initial Level of Care evaluation determinations are made by the Bureau of TennCare which maintains all applicable written and electronic documentation for a minimum of 3 years.

Annual Level of Care Reevaluations: Annual Level of Care Reevaluations are conducted by DIDD, which maintains all applicable written and electronic documentation for a minimum of 3 years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

Sub-Assurances:

Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.a.2. Number and percentage of new waiver participants for whom level of care eligibility was approved prior to enrollment in the waiver. Percentage = number of newly enrolled waiver participants for whom level of care eligibility was approved prior to enrollment in the waiver/total number of newly enrolled waiver participants.

Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
[blank – deleted per CMS Modifications March 2014]

Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.c.3. Number and percentage of initial level of care determinations made for which LOC criteria were accurately and appropriately applied. Percentage = number of initial LOC determinations made in which LOC criteria were accurately and appropriately applied/ total number of initial LOC decisions.
a.i.c.7. Number and percent of ICF/IID level of care eligibility determinations made within 8 working days of receipt of application. Percentage = Number of determinations made within 8 days/ total number of applications received.
a.i.c.1. Number and percentage of initial level of care determination made by a qualified evaluator (i.e. Registered Nurse). Percentage = number of LOC determinations made by a qualified evaluator / total number of LOC determinations.

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

Note: performance measures a.i.b.1 and a.i.c.6 have been deleted because the related subassurance, "The levels of care of enrolled participants (persons supported) are reevaluated at least annually or as specified in the approved waiver," was removed per the CMS Modifications guidance released in March 2014.

Performance Measures a.i.c.3: TennCare will select a monthly sample of PAEs reviewed for ICF/IID level of care during the previous month. For each PAE in the sample, a PAE Nurse who was not involved in the original review will be assigned to conduct a "follow-behind" review to ensure ICF/IID level of care criteria were appropriately utilized in approving or denying the PAE.

Performance Measures a.i.c.3.: TennCare will select a monthly sample of PAEs reviewed for ICF/IID level of care during the previous month. For each PAE in the sample, a PAE Nurse who was not involved in the original review will be assigned to conduct a "follow-behind" review to ensure ICF/IID level of care criteria were appropriately utilized in approving or denying the PAE.

Methods for Remediation/Fixing Individual Problems

1. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem

correction. In addition, provide information on the methods used by the State to document these items.

Performance Measures a.i.a.2.: Actual enrollment into the CAC waiver is managed by TennCare once all necessary requirements have been met. This includes the loading of an approved PAE (i.e., level of care) eligibility segment into the MMIS. Thus, enrollment is not permitted without a level of care determination. Further, the TennCare MMIS Edit 2008 does not allow payment for waiver services until an approved PAE is entered into the MMIS. Edit reports generated from the MMIS will be utilized for TennCare staff to identify instances where claims for waiver services were denied due to the absence of a PAE eligibility segment. When such instances are discovered, TennCare staff will investigate whether the unit neglected to enter the PAE information into the system or whether a claim was submitted when there was no current approved PAE on file. If TennCare staff failed to enter the PAE information in the system, the error will be corrected upon discovery and staff who made the error will be counseled as appropriate. If a claim was submitted before a PAE was approved or submitted or for an expired PAE, DIDD will be notified via the Remittance Advice Report. DIDD will be required to submit a PAE, update an expired PAE, or await approval of a pending PAE, as applicable. Any payment will be contingent upon the effective date of level of care eligibility and enrollment into the waiver. Services provided prior to a person's level of care eligibility and enrollment into the waiver will not be reimbursed. TennCare's goal for resolution of claims denials related to "no PAE on file" is 30 calendar days.

Performance Measure a.i.c.1.: Only registered nurses employed and trained by TennCare to review PAEs may render a level of care decision. Only those PAEs approved by TennCare review nurses are entered into the MMIS to allow payment of claims. Upon discovery that an unqualified individual approved or denied a PAE, TennCare will assign a qualified TennCare PAE nurse to complete a re-review of the application within 8 business days. The corrected PAE with the signature of the qualified TennCare PAE nurse who approved the PAE upon re-review will be forwarded to the applicant and appropriate Case Manager within 3 business days of the re-review decision being made, with a cover letter explaining that the previous PAE is invalid and that the new PAE, signed by a qualified TennCare PAE reviewer, should be used to demonstrate medical eligibility for services. TennCare will then apply an end-date to the MMIS segment pertaining to the PAE approved in error, so that claims cannot be billed using that PAE. If an original PAE review results in approval by an unqualified reviewer, and such approval is determined to be in error upon re-review, TennCare will send a corrected denied PAE (including the signature of the qualified TennCare PAE reviewer) to the appropriate DIDD case manager and a notice of denial to the waiver participant, copied to the appropriate Support Coordinator. Both will be issued within 3 business days of the new determination being made. The notice of denial will include a description of applicable appeal rights. A cover letter will be attached advising the applicant that a wrongful determination was made by an unqualified reviewer and that DIDD will be required to begin disenrollment procedures upon exhaustion of appeal rights. DIDD will complete and issue a waiver disenrollment notice (reviewed by TennCare prior to issuance) if no appeal is received within 30 calendar days of the waiver participant's receipt of the erroneous PAE approval notice. If an appeal is received within 30 calendar days of the waiver participant's receipt of the notice and a fair hearing is held, DIDD will issue notice of disenrollment upon receipt of a final order indicating that the applicant is ineligible for waiver services. In the event that the applicant is approved via the fair hearing, waiver funds will be used to pay for service claims. If the applicant is finally determined to be ineligible through appeal processes, the state will not claim FFP for reimbursement of services rendered prior to disenrollment. TennCare will track and report the number of PAEs re-reviewed due to prior disposition by an unqualified reviewer as well as approvals, denials, and appeals generated by re-reviews.

Performance Measures a.i.c.7: When TennCare review of the PAE process determines that ICF/IID PAEs were not completed within 8 business days of receipt, the PAE Unit Supervisor will verify that the PAE

has been properly completed, determine why the PAE was not completed timely, and counsel staff and/or adjust operational procedures as necessary. Remediation is expected within a targeted time frame of 30 calendar days.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

FREEDOM OF CHOICE

1. When an individual is determined to qualify in the target group specified for the CAC waiver, (including additional target criteria specified in Appendix B-1(b)) and to meet all other applicable requirements for enrollment into the CAC waiver, including ICF/IID level of care, and the waiver capacity has not reached the specified cap of unduplicated participants for the year, the individual or his or her legal representative will be:

- a. informed of any feasible alternatives under the waiver; and
- b. given the choice of either institutional or Home and Community-Based services.

PROCESS:

The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:

When an individual is determined to require the level of care provided by an ICF/IID, DIDD shall inform the individual or the individual's legal representative of any feasible alternatives available under the waiver program, including a description of the waiver services and names and addresses of available qualified providers, and shall offer the choice of either institutional or waiver services.

Notice to the individual shall contain a simple explanation of the waiver and waiver services; a statement that participation in the Waiver is voluntary; and notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment. The Freedom of Choice form shall be explained and the signature of the person to receive waiver services or the legal representative will be obtained on the Freedom of Choice form, which will be completed prior to admission into the waiver program.

In addition to freedom of choice of institutional or HCBS alternatives, individuals electing to participate in the CAC waiver shall be supported to exercise informed choice regarding services and supports they receive, providers of such services, and the setting in which services and supports are received and which shall be integrated in, and support full access to the greater community, including opportunities

to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of freedom of choice documentation are maintained in the following location(s):
The Freedom of Choice documentation will be maintained by contracted Support Coordination Agencies.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

For Individuals with Limited English Proficiency (LEP)

The Bureau of TennCare, the Department of Human Services, and the Department of Intellectual and Developmental Disabilities (DIDD) provide a number of options to assist individuals with Limited English Proficiency (LEP) as they navigate the application process for TennCare eligibility.

The Bureau of TennCare provides eligibility applications and mails notices in English and Spanish. An insert in each TennCare mailing provides information in each of the following languages and a toll-free phone number that individuals may call for translation assistance: Arabic, Kurdish-Bandinani, Kurdish-Sorani, Bosnian, and Vietnamese. Translation services are provided by the TennCare Advocacy Program, a program of Health Assist Tennessee. In addition to translation services, the TennCare Advocacy Program also assists TennCare enrollees and applicants with TennCare questions or problems, and can direct enrollees and applicants to other local community resources for translation and other assistance. DIDD also provides translation services as needed.

All notices contain the numbers of the TennCare Solutions Unit, the TennCare Advocacy Program and a TTY/TDD line.

The Bureau of TennCare provides a list of accommodations that are made available to the TennCare population. These accommodations include:

- Accepting online applications;
- Accepting applications submitted through the U.S. Mail;

- Allowing the applicant to designate a third party to represent him/her during the eligibility process;
- Conducting the interview or discussion that might be needed to gather additional information over the phone or outside normal working hours;
- When needed because of the applicant’s disability, providing in-home assistance in completing the application process.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

1. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Residential Habilitation
Statutory Service	Respite
Statutory Service	Support Coordination
Extended State Plan Service	Nursing Services
Extended State Plan Service	Nutrition Services
Extended State Plan Service	Occupational Therapy
Extended State Plan Service	Physical Therapy
Extended State Plan Service	Specialized Medical Equipment and Supplies and Assistive Technology
Extended State Plan Service	Speech, Language, and Hearing Services
Other Service	Behavior Services
Other Service	Behavioral Respite Services
Other Service	Dental Services
Other Service	Employment and Day Services

Service Type	Service
Other Service	Environmental Accessibility Modifications
Other Service	Family Model Residential Support
Other Service	Individual Transportation Services
Other Service	Intensive Behavioral Residential Services
Other Service	Medical Residential Services
Other Service	Orientation and Mobility Services for Impaired Vision
Other Service	Personal Assistance
Other Service	Personal Emergency Response System
Other Service	Semi Independent Living
Other Service	Supported Living
Other Service	Transitional Case Management

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

2. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable - Case management is not furnished as a distinct activity to waiver participants.
- Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.

Appendix C: Participant Services

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

1. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- No. Criminal history and/or background investigations are not required.
- Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Any staff person who has direct contact with or direct responsibility for the person supported must pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD) and must not be listed on the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender List, or the Office of Inspector General List of Excluded Individuals and Entities.

A statewide criminal background check is performed by the Tennessee Bureau of Investigation or a Tennessee-licensed private investigation company. If the staff person has resided in Tennessee for one year or less, a nationwide criminal background check is required in accordance with DIDD requirements. During Qualified Provider Reviews conducted by DIDD, the provider's personnel files are reviewed to ensure that there is documentation that the mandatory background and registry checks have been conducted on potential staff who will have direct contact with or direct responsibility for the person supported.

Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies

referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Tennessee Department of Health maintains the State's Abuse Registry under the authority of T.C.A. 68-11-1001, et seq.

The provider agreement requires that each provider have background and registry checks completed for all new employees whose responsibilities include direct care for a person supported and any current employees who have a change in job responsibilities to include direct care for a person supported, prior to, but no more than 30 calendar days in advance of, employment or a change in duties. This requirement includes specifically: (1) an appropriate background check completed by either the Tennessee Bureau of Investigation or a company licensed by the state to conduct such checks; (2) a check of the Tennessee Department of Health Abuse Registry; (3) a check of the Tennessee Sexual Offender Registry; (4) a check of the Tennessee Felony Offender List; and (5) a check of the Office of Inspector General List of Excluded Individuals and Entities.

The process for ensuring that these checks have been completed appropriately and timely is part of the quality assurance survey process set forth in the waiver application (see performance measure a.i.a.6.). During the provider performance review, determination is made as to the provider's compliance with the above requirements through a check of personnel records for all new employees and employees with a change in job responsibilities to include direct care for a person supported (existing employees would have already been verified). Should there be any deficiencies in a provider's performance within this area, the provider is required to correct the deficiencies within 30 calendar days of discovery. DIDD collects data regarding compliance with these requirements and remediation of deficiencies, and reports monthly to TennCare in performance measure compliance reports. Furthermore, DIDD conducts monthly checks of the Office of Inspector General List of Excluded Individuals and Entities for all providers and sends the monthly reports directly to TennCare Program Integrity.

Appendix C: Participant Services

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

Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

1. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type
Intermediate Care Facilities for individuals with Intellectual Disabilities
Licensed Residential Provider

Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The only services in this waiver that may be provided in a residential setting serving 4 or more unrelated individuals include Residential Habilitation or Medical Residential Services provided in a facility setting selected by the person supported and licensed to serve more than 4 people as of July 1, 2000, as well as Respite or Behavioral Respite that might be provided in such facilities, the latter two of which are provided on a temporary, short-term basis. All facilities licensed on or after July 1, 2000 serve 4 or fewer individuals. All facilities providing HCBS, including those licensed to serve more than 4 people as of July 1, 2000, must 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. Services are not provided in ICFs/IID or facilities that are "institutional" in nature.

Appendix C: Participant Services

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

Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant.

Select one:

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of extraordinary care by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.

Family members may be employed by a provider agency selected by the person supported to provide waiver services, including Personal Assistance. Family members who provide Personal Assistance or any other waiver service as permitted in accordance with the waiver service definition must meet the same standards as staff who are unrelated to the person supported and shall not be the spouse and shall not be the parent or custodial grandparent if the person supported is a minor.

This requirement includes implementing services as specified in the Individual Support Plan.

Reimbursement to family members shall be limited to forty hours per week per family member and shall not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

The person supported, working with his/her Circle of Support, as desired and appropriate, is responsible for determining if the use of family members to deliver his/her paid care is the best choice.

Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order of Conservatorship [T.C.A.1200-13-1-.25(3)].

The state makes such allowances for the best interest of the person supported. Payment to family members is intended to promote a more family-oriented residential environment, allowing the person supported to stay in their own home. This promotes family involvement in the life of the person, with the intent to strengthen the person's family unit.

Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered

A spouse or the parent or custodial grandparent or guardian of a minor child shall not be employed and paid by a provider agency to provide waiver services. In Tennessee, "guardian" refers to the legally responsible person for a minor.

Family members employed by a provider agency who provide Personal Assistance or any other waiver service as permitted in accordance with the waiver service definition must meet the same standards as providers who are unrelated to the person supported and shall not be the spouse and shall not be the person supported parent or custodial grandparent if the person supported is a minor.

Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order of Conservatorship [T.C.A. 1200-13-1.25(3)1].

Such service providers are also subject to review by both DIDD and the State Medicaid Agency reviewers. Family members who are providers are expected to abide by all applicable state and federal guidelines, as well as all policies administered by either DIDD or the State Medicaid Agency.

Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

TennCare and the Department of Intellectual and Developmental Disabilities (DIDD) allow for enrollment of all willing and qualified providers of waiver services during recruitment cycles. The DIDD web site provides information to interested providers regarding the DIDD enrollment process; which includes obtaining a provider application, Applicant Forums and information regarding Open and Targeted Enrollment (recruitment cycles). Information regarding the provider enrollment process, provider qualifications for waiver services and other helpful information is also available to prospective services on the DIDD website and by contacting designated staff at DIDD whose contact information is posted online. All information and forms mentioned are available at all times to potential providers.

All applications submitted by providers are reviewed by DIDD and submitted to TennCare for enrollment as a waiver provider if the specified qualifications are met.

Prospective providers are given the opportunity to respond to any questions or additional information requested to complete the application. DIDD staff are available to address any questions the prospective provider may have regarding the application process.

In addition to the provider qualifications specified in Appendix C-1 for each HCBS service, the following general requirements apply to all providers of waiver services:

- All providers shall be at least 18 years of age.
- Staff who have direct contact with or direct responsibility for the person supported shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
- Any waiver service provider who is responsible for transporting a person supported shall ensure that the driver has a valid driver's license and current automobile liability insurance.
- Staff who have direct contact with or direct responsibility for the person supported shall pass a criminal background check performed in accordance with a process approved by DIDD.
- Staff who have direct contact with or direct responsibility for the person supported shall not be listed in the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender List, or the Office of Inspector General List of Excluded Individuals and Entities.
- Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
- All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-Assurances:

Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.a.6. # and % of newly employed (or reassigned) direct support staff serving waiver participants who had Abuse Registry checks completed prior to, but no more than 30 days in advance of employment or a change in assignment to direct support. % = # of newly employed/reassigned DSS with timely Abuse Registry checks/total number of newly employed DSS serving waiver participants in the QP sample.
a.i.a.11. # and % of newly employed (or reassigned) direct support staff who transport waiver participants and who had a current driver's license. Percentage = number of newly employed (or reassigned) DSS who transport waiver participants and had a current driver's license / total number of newly employed (or reassigned) direct support staff serving waiver participants in the QP sample.
a.i.a.10. # and % of newly employed (or reassigned) direct support staff delivering services to waiver participants who are able to read, write, and communicate in English. % = # of newly employed (or reassigned) direct support staff who are able to read, write, and communicate in English / total # of newly employed (or reassigned) direct support staff serving waiver participants in the QP sample.
a.i.a.2. # and % of new provider applications received for which criminal background checks were passed and registry and reference checks were completed for identified executive staff prior to approval of the application. Percentage = number of applications documenting required background, registry, and reference checks / total number of applications approved.

Performance Measure
a.i.a.5. # and % of newly employed (or reassigned) direct support staff serving waiver participants who passed background checks prior to, but no more than 30 days in advance of, employment or a change in assignment to direct support. % = # of newly employed/reassigned DSS with timely background checks/total number of newly employed (or reassigned) DSS serving waiver participants in the QP sample.
a.i.a.1 # & % of approved new providers who met all applicable qualifications (e.g. licensure/certification, background and registry checks, references) prior to service provision. % = # of newly approved providers meeting all qualifications/ total # of newly approved providers.
a.i.a.4. Number and percentage of providers who continued to meet applicable licensure/certification following initial enrollment. Percentage = number of providers who maintained licensure/certification / total number of providers surveyed for which licensure/certification is required.
a.i.a.7. # and % of newly employed/reassigned DSS serving waiver participants with Sexual Offender Registry checks completed prior to, but no more than 30 days in advance of employment or reassignment to direct support. % = # of newly employed/reassigned DSS with timely Sexual Offender Registry checks/total number of newly employed/reassigned DSS serving waiver participants in the QP sample.
a.i.a.8. # and % of newly employed/reassigned DSS serving waiver participants who had Tennessee felony checks completed prior to, but no more than 30 days in advance of employment or a change in assignment to direct support. % = # of newly employed/reassigned DSS with timely Tennessee felony Registry checks/total number of newly employed/reassigned DSS serving waiver participants in the QP sample.
a.i.a.16: Newly employed (or reassigned) direct support staff serving waiver participants with federal List of Excluded Individuals/Entities (LEIE) checks completed prior to, but no more than 30 calendar days in advance of employment, or a change in assignment to direct support.

Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or

inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.b.1. Number and percentage of non-licensed/non-certified providers who met waiver provider qualifications. Percentage = number of unlicensed/non-certified providers who met waiver provider qualifications / total number of unlicensed/non-certified providers in the QP sample.

Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.c.1. # and % of newly employed (or reassigned) direct support staff delivering services to waiver participants who completed required training prior to direct service delivery. Percentage = # of newly employed (or reassigned) direct support staff who completed required training / total number of newly employed (or reassigned) direct support staff serving waiver participants in the QP sample.

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

Note: The State added a.i.a.16 to reflect the ongoing requirement that Newly employed (or reassigned) direct support staff serving waiver participants (persons supported) with federal List of Excluded Individuals/Entities (LEIE) checks completed prior to, but no more than 30 calendar days in advance of employment, or a change in assignment to direct support.

Performance Measures a.i.a.4., a.i.a.5. through a.i.a.11, a.i.b.1, and a.i.c.1: Qualified Provider Reviews and Provider Performance Surveys are conducted annually for 100% of provider agencies who employ two (2) or more staff. Providers who achieve exceptional or proficient Provider Performance Survey scores, who achieve substantial compliance in Domain 3: Safety and Security, who have a substantiated rate of investigation which is less than 10 per 100, and who have no suspicious deaths since the previous provider performance survey qualify for reduction in the frequency (i.e., every two years) of the

Provider Performance Survey. A representative sample of independent providers (e.g., physical therapists, occupational therapists, speech language pathologists, audiologists, nurses, nutritionists, and behavior service providers) who do not employ any additional staff (i.e., the provider consists of one person) will be surveyed/reviewed annually.

Performance Measure a.i.a.5.: Tennessee Code Annotated (33-2-1201) states: "Each organization shall have a criminal background check performed on each employee whose responsibilities include direct contact with or direct responsibility for persons supported."

- **Methods for Remediation/Fixing Individual Problems**

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

Performance Measures a.i.a.1. through a.i.a.3.: Providers who do not meet the requirements specified in these performance measures will not be allowed to sign a Provider Agreement, enroll in the DIDD and/or TennCare MMIS claims processing systems, or receive payment for services rendered. Applications that do not meet requirements will be denied. Written denials of provider applications will indicate which requirements have not been met and advise that the provider may reapply for consideration with additional documentation that such requirements have been met.

Performance Measure a.i.a.4.: When DIDD identifies that an existing provider has not maintained required licensure/certification, DIDD will notify TennCare within two (2) working days so that funds may be recouped for payment of any past period during which services were billed while the provider qualifications were not met. The Provider Agreement will be terminated unless proof of licensure/certification is submitted to DIDD within 30 days of the date the issue was identified. The provider will not be eligible for payment of claims until licensure/certification issues are resolved.

Performance Measures a.i.a.5. through a.i.a.8.: DIDD will review a sample of provider agency staff personnel records during Qualified Provider Reviews. A Qualified Provider Review will be conducted with the contracted fiscal management agency annually. For individual direct support staff who did not have required background/registry checks at the time of the Qualified Provider Review, DIDD will request that the background and/or registry check be initiated during the review. Designated DIDD Regional Office staff will be responsible for verifying that the background/registry check was obtained and reviewing the results. If staff did not pass the background/registry check, DIDD will require the provider agency or fiscal management agency to take appropriate personnel action(s), and designated DIDD Regional Office staff will verify that appropriate action was taken within 30 days of the provider's receipt of the completed background check.

For staff in the sample who commit a serious criminal offense during the course of employment, DIDD will determine if the provider agency or fiscal management agency took appropriate action, or if action is pending, will verify that action was taken within 30 days of discovery. Failure to obtain background or registry checks in accordance with state law and DIDD requirements and/or failure to take appropriate personnel actions may result in sanctions, including institution of a moratorium on serving new waiver participants.

Performance Measure a.i.a.9.through a.i.a.11: DIDD will review a sample of staff personnel records during Qualified Provider Reviews. For individual direct support staff who did not meet waiver general qualifications, DIDD will notify the provider or fiscal management agency and request that appropriate personnel action be taken, which may include termination of the employee, ensuring that the employee acquire the skills needed to meet general requirements, or reassignment to a non-contact position. Designated DIDD Regional Office staff will be responsible for verifying that the appropriate actions were taken within 30 days of discovery.

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

Individual Remediation Data Aggregation: DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible DIDD staff and back-up staff are identified for each task. Designated DIDD Central Office staff compile the data collected and entered by regional and central office staff into DIDD databases to create data files that are posted for TennCare analysis and aggregation. In addition, DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings.

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

1. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, [HCB Settings Waiver Transition Plan](#) for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Services are provided in a person's home and community. All settings in which HCBS are provided are selected by the person supported and support each resident's independence and full integration into the community, and ensures each resident's choice and rights. HCBS providers 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 Individual Support Plan (ISP).

All individual goals and objectives, along with needed supports are 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.

Each provider is assessed to ensure that each service is being delivered to all service persons supported in a manner that comports with the HCBS settings rule. In addition, an assessment of each person's experience is embedded into the person-centered planning process on an ongoing basis to ensure that services and supports received by that person are non-institutional in nature, and consistent with the requirements and objectives of the HCBS settings rule.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

1. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Licensed physician (M.D. or D.O)

- Case Manager (qualifications specified in Appendix C-1/C-3)
- Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The Independent Support Coordinator (ISC) must have:

1. A Bachelor's degree from an accredited college or university in a human services field; or
2. A Bachelor's degree from an accredited college or university in a non-related field and one (1) year of relevant experience; or
3. Associate degree plus two (2) years of relevant experience; or
4. High School diploma or general educational development (GED) certificate plus four (4) years of relevant experience.

Relevant experience as it relates to Independent Support Coordinators means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness. Independent Support Coordinators who do not have a Bachelor's degree in a human services field must be supervised by someone who does meet that qualification.

Support coordination provider agencies are required to ensure that persons employed to render support coordination services receive effective guidance, mentoring, and training, including all training required by DIDD. Effective training must include opportunities to practice support coordination duties in a manner that promotes development and mastery of essential job skills.

The intent of providing independent support coordination is to ensure that planning and coordination of services is conflict-free. Thus, providers of independent support coordination services are prohibited from providing both support coordination and other direct waiver services. Support coordination providers must maintain an office in each grand region where services are provided.

Support Coordination must be conducted in a manner that ensures person-centered planning processes and practices are followed pursuant to all applicable state and federal regulations.

Other

Specify the individuals and their qualifications:

The Support Coordinator must have:

1. A Bachelor's degree from an accredited college or university in a human services field; or
2. A Bachelor's degree from an accredited college or university in a non-related field and one (1) year of relevant experience; or
3. Associate degree plus two (2) years of relevant experience; or
4. Four (4) years of relevant experience.

Relevant experience as it relates to Support Coordinators means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.

Support coordinators who do not have a Bachelor's degree in a human services field must be supervised by someone who does meet that qualification.

Support Coordinators must successfully complete required pre-service training courses as well as periodic in-service training and any other any re-training required to maintain approval to be a Support Coordinator.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

Service Plan Development Safeguards. *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

As part of the enrollment process into the waiver, DIDD intake staff advise and explain to the individual or person legally authorized to act on behalf of the individual (as applicable), the operation of the waiver program and waiver services offered as an alternative to care in an Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID), including the person's right to direct the person-centered planning process. The intake staff should discuss with the person and any legally authorized representative, the supports the person will need to engage in the development of the initial ISP, and will help to arrange for such supports, and actively engage the person and others he designates in the development of the initial ISP. Intake staff will review the PreAdmission Evaluation (PAE) and the initial ISP with the person and his representative, provide a list of available service providers with contact information, and answer any questions related to the waiver. The intake staff person will provide information, including a copy of the Family Resource Guide, to the person supported or person's family representative. The Family Resource Guide is a guide available to support services for family members of individuals with intellectual disabilities. The intake staff are also expected to share information about non-state services and supports such as community resources, etc.

Once enrolled in the waiver, all persons supported have an Independent Support Coordinator who is responsible for facilitating the development of the ISP; ensuring that person-centered planning process is driven by the person supported, as appropriate; services are initiated within required time frames; and conducting ongoing monitoring of the implementation of the ISP and the person's health and welfare.

The Independent Support Coordinator is responsible for providing necessary information and support to the individual to support his/her direction of the person-centered planning process to the maximum extent desired and possible. The person supported has the authority to decide who is included in the development of the (ISP).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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

Independent Support Coordinators (ISCs) assist persons supported in identifying their needs and preferences and selecting, obtaining and coordinating services using paid and natural supports. The ISC, in collaboration with the person supported, the person supported authorized representative (if applicable), other persons specified by the person supported (this may include family members, friends, and paid service providers selected by the person) convene at time and location convenient to the person supported, in a formal Planning Meeting to discuss and finalize the ISP which is the person-centered ISP. Prior to the development of the ISP, waiver services are provided in accordance with the initial ISP included in the approved ICF/IID PAE. The time period for development of the ISP after enrollment into the waiver program is 60 calendar days.

Each person-centered planning process must:

- a. Be directed by the individual to the greatest extent possible,
- b. Identify strengths and needs, both clinical and support needs, and desired outcomes,
- c. Reflect cultural considerations and use language understandable by the individual
- d. Include strategies for solving disagreements
- e. Provide method for individual to request updates to be made to their ISP

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

- a. An assessment of the individual's status, adaptive functioning, and service needs through the administration of a uniform assessment instrument (such as the Supports Intensity Scale);
- b. The identification of individual risk factors through the administration of the Risk Issues Identification Tool, and identification of strategies to mitigate risks, including documentation of the individual's understanding of the risks and mitigation strategies, including documentation that those strategies have been clearly explained;
- c. Additional assessments, where appropriate, by health care professionals (e.g., occupational or physical therapists, behavior analysts, etc.);
- d. The identification of personal outcomes, support goals, supports and services needed, information about the person's current situation, what is important to the person supported, and changes desired in the person's life (e.g., home, work, relationships, community membership, health and wellness). (Information for the ISP will be gathered and developed through the person-centered planning process driven, to the greatest extent possible, by the person supported and, if applicable, in collaboration with the guardian or conservator, as well as family members and other persons specified by the person supported.);
- e. 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; and
- f. Waiver and other services are coordinated by the ISC through the development and implementation of the ISP. The ISP describes all the supports and services necessary to support the person to achieve their desired outcomes and attain or maintain a quality life as defined by them, including services that may be provided through natural supports, the Medicaid State Plan or pursuant to the person's Individual Education Plan (IEP).

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

A formal Planning Meeting which is convened to finalize the ISP.

The ISP is the fundamental tool by which the state ensures the health and welfare of the individuals served under this waiver. As such, it is subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the person's disability and are responsive to the person's needs and preferences. Ongoing monitoring by the ISC is accomplished through monthly face-to-face monitoring visits. When an individual is residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. The frequency of face-to-face visits shall be specified in the ISP and may occur more frequently when needed. Completion of a monthly status review of the ISP will be documented for each individual per service received.

The ISP will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service regardless of funding source. As required pursuant to the federal Personal Centered Planning Rule, the ISP shall be signed by the individual and all persons involved in implementing the plan, including those providing paid and or unpaid supports.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

In addition, the State has a system in place for assuring emergency backup and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While the state may define and plan for emergencies on an individual basis, the state also must have system procedures in place.

As a result of the administration of the Risk Issues Identification Tool, situations will be identified when access to emergency backup services could be required and appropriate person-centered strategies will delineate how emergency backup services will be triggered and responsibilities for ensuring that such services are furnished. As appropriate, strategies will identify informal (unpaid) supports that could assist in meeting emergency backup needs.

As a third tier of emergency backup services, regional office personnel or staff from a state Developmental Center will directly furnish the emergency backup services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Participation in a waiver program is voluntary. Prior to being enrolled in a waiver, a qualified applicant has the right to freely choose whether they want to receive services in the waiver or in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Freedom of choice also includes the right to select any provider with an active provider agreement with the Department of Intellectual and Developmental Disabilities (DIDD) and the Bureau of TennCare if the provider is available, willing, and able to provide the services needed, and choice of 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.

The state assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written ISP. The ISC will provide information about selecting from among qualified providers of the waiver services in the ISP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The initial ISP must be submitted to TennCare as part of the PreAdmission Evaluation (PAE or level of care) application. All initial ISPs are reviewed and approved as part of the PAE. While subsequent plans of care are reviewed and approved by DIDD, they remain subject to the review and approval of TennCare at TennCare's discretion. TennCare reviews the adequacy and appropriateness of ISP through the quality assurance process set forth in the waiver application (see Appendix D). In addition, TennCare regularly reviews ISPs as part of the utilization review process which is described in Appendix I.

Appendix D: Participant-Centered Planning and Service Delivery

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

8. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary

• **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Independent Support Coordinators (ISC) assist persons supported in identifying needs and preferences, and in selecting, obtaining, and coordinating services using paid and natural supports. Ongoing monitoring by ISCs is essential and they are responsible for determining if services are being implemented as specified in the ISP and if the services described in the plan are meeting the person's needs. Monitoring by ISCs is accomplished through completing a minimum of one face-to-face visit each month and by completing a Monthly Status Review of the ISP across all service delivery environments. If the person is receiving residential services, one face-to-face per quarter (i.e. once every 3 months) must be conducted in the person's place of residence. The frequency of monitoring visits shall be specified in the ISP and may be provided more frequently as needed. Information is gathered using standardized processes and tools.

The ISC reports issues identified to management staff from the appropriate provider agencies. DIDD Regional Office management staff may assist in achieving resolution when timely provider response does not occur.

All individuals who receive supports and services through DIDD are required to have an annual risk assessment. This assessment is a component of the planning process intended to identify potential risks and create an environment that establishes appropriate safeguards without limiting personal experiences. Risk management is accomplished through risk assessment and identification of risk factors, risk analysis and planning, ongoing evaluation of the effectiveness of risk management strategies, and staff training and re-training as appropriate.

The success of individual strategies to ameliorate individual risks identified through risk assessment are evaluated by the person supported, their families and significant others, providers, and the ISC as part of on-going planning for and monitoring of services.

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

Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-Assurances:

Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.a.4. # and % of consumer satisfaction survey respondents who reported that the things important to them were addressed in their Individual Support Plan. % = # of survey respondents who reported that the things important to them were addressed in their ISP / total # of waiver participants in the sample who responded to this survey question.
a.i.a.2. Number and Percentage of waiver participants who have Individual Support Plans with measureable action steps applicable to each of the outcomes specified. Percentage = number of waiver participants who have ISPs with measurable action steps for each outcome/ total number of waiver participants in the sample.

Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
[blank – deleted per CMS Modifications March 2014]

Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.c.1. Number and Percentage of Individual Support Plans reviewed and revised (as needed) before the annual review date. Percentage = Number of waiver participants whose Individual Support Plans were reviewed/revised before the annual review date / total number of waiver participants in the sample.
a.i.c.2. Number and Percentage of waiver participants whose Individual Support Plans were revised, as applicable, by the ISC/case manager to address their changing needs. Percentage = Number of participants' Individual Support Plans that were revised, as applicable/ total number of waiver participants who required a revised ISP due to changing needs.

Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.d.2. Number and Percentage of waiver participants who received the amount of service specified in the approved Individual Support Plan. Percent = number of waiver participants receiving the amount of services in the ISP/ total number of waiver participants in the sample less TennCare approved and

Performance Measure
documented exceptions.
a.i.d.4. Number and Percentage of waiver participants who received services for the duration specified in the approved Individual Support Plan. Percentage = number of waiver participants receiving services for the duration specified in the ISP/ total number of waiver participants in the sample less TennCare approved and documented exceptions.
a.i.d.3. Number and Percentage of waiver participants who received services at the frequency specified in the approved Individual Support Plan. Percentage = number of waiver participants receiving services at the frequency specified in the ISP/ total number of waiver participants in the sample less TennCare approved and documented exceptions.

Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.e.5. Number and Percentage of waiver participants whose records contained documentation that the service recipient or guardian/conservator, as applicable, was provided with a list of qualified waiver providers. Percentage = number of waiver participants whose records documented provision of a list of waiver providers / total number of waiver participants in the sample.
a.i.e.4. Number and Percentage of waiver participants whose records contained documentation that the service recipient or guardian/conservator, as applicable, was provided with a list of waiver services. Percentage = number of waiver participants whose records documented provision of a list of waiver services / total number of waiver participants in the sample.

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

Per the CMS Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers released March 12, 2014, the following performance measures have been deleted: SPa.i.b1, b2, b3, b6, b7, b8. Those performance measures were deleted because the related subassurance, "The state monitors service plan development in accordance with its policies and procedures" was deleted per the CMS Modifications. Per the same guidance, SP - a.i.e.1. was also deleted, "Waiver participants whose records contained the current Freedom of Choice form completed and signed by the participant or his/her guardian or conservator, which specifies that choice was offered between waiver services and institutional care."

Performance Measures a.i.c.1. and a.i.c.2., a.i.d.2. through a.i.d.4., and a.i.e.4. and a.i.e.5.: A representative sample of waiver participants will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible to collect data during the following twelve (12) months. For each waiver participant included in the sample, Individual Record Reviews will be conducted by designated DIDD Regional Office staff. Staff will review waiver participant records, including claims data, to obtain the information needed to determine compliance with these performance measures.

Methods for Remediation/Fixing Individual Problems

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

Performance Measures a.i.c.1. and a.i.c.2., and a.i.e.2.: Designated DIDD Regional Office staff will notify Support Coordination Agencies and other provider agencies as appropriate when service planning and implementation compliance issues are identified. Regional Office staff will monitor remediation actions until able to verify that the issue has been resolved satisfactorily. Remediation actions and timeframes are reported to TennCare monthly. TennCare notifies DIDD of any remediation determined unacceptable and requires DIDD to provide additional information and/or take additional remedial action until remediation can be determined appropriately completed. Support Coordination agencies will be held accountable for ensuring necessary corrections are made to Individual Support Plans, for taking appropriate personnel actions, and for reporting remedial actions and resolution dates to DIDD Regional Office staff. Other contracted providers will be held accountable, as appropriate, for resolution of issues involving ISP/plan of care implementation. Remediation actions are expected to be completed within a targeted time frame of 30 days.

Performance Measure a.i.a.4.: When individuals report issues with the ISP/plan of care, the satisfaction survey interviewer will notify the DIDD People Talking to People Director within three working days. The DIDD People Talking to People Director will take appropriate action, which could include filing a complaint if appropriate and in accordance with the waiver participant's wishes, or notifying the Support Coordinator of the waiver participants need to consider plan amendment. The DIDD People Talking to People Director will monitor remedial actions and track remediation timeframes. Complaints filed will be resolved in accordance with DIDD complaint resolution processes. DIDD goal is to resolve

complaint issues within a 30 day time frame. Designated DIDD staff will compile monthly information about complaints and complaint resolution, including complaint types and referral sources, into data files and the Quality Management Report, all of which will be submitted monthly to TennCare. Appeals filed will be processed in accordance with TennCare rules and TennCare approved DIDD policy.

Performance Measure a.i.d.2. through a.i.d.4.: TennCare and DIDD have determined that there are acceptable reasons when services may not be provided exactly in accordance with plan specifications. Such acceptable reasons (e.g., holidays, inclement weather, service recipient choice, hospitalization) have been identified and shared with DIDD staff and waiver service providers through a memorandum. When service amount, frequency, or duration varies for acceptable reasons, compliance is indicated; however, data is tracked regarding the reasons services were not provided in the amount, frequency, and duration in approved plan. In situations where more services were billed than were actually provided or documented, DIDD reviewers will forward this information to designated DIDD administrative staff who will initiate recoupment procedures. If warranted, a provider may be referred to DIDD audit staff for a more extensive fiscal audit. The DIDD Deputy Commissioner will determine the need for more extensive provider level fiscal audits during monthly State Quality Management meetings.

Individual Remediation Data Aggregation: DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible DIDD staff and back-up staff are identified for each task. Designated DIDD Central Office staff compile the data collected and entered by regional and central office staff into DIDD databases to create data files that are posted for TennCare analysis and aggregation. In addition, DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Medicaid Agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the

institutional care or who are denied the service(s) of their choice, or the provider(s), services and settings of their choice.

PROCESS:

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

1. A plain language explanation of appeal rights shall be provided to persons supported upon enrollment in the waiver.
 2. DIDD shall provide in advance a plain language written notice to the persons supported of any action to delay, deny, terminate, suspend, or reduce waiver services, including the setting in which services and provided, or of any action to deny choice of available qualified providers.
 3. Notice must be received by the persons supported prior to the date of the proposed termination, suspension, or reduction of waiver services unless one of the exceptions exists under 42 CFR 431.211-214.
 4. A persons supported has the right to appeal the adverse action and to request a fair hearing.
 5. Appeals must be submitted to the Bureau of TennCare within thirty (30) calendar days of receipt of notice of the adverse action. Receipt of any notice shall be presumed to be within five (5) calendar days of the mailing date.
 6. Reasonable accommodations shall be made for persons with disabilities who require assistance with the appeal process.
 7. Hearings shall be held pursuant to the provisions of the Tennessee Uniform Administrative Procedures Act and shall be held before an impartial hearing officer or administrative judge.
 8. A written hearing decision shall be issued within ninety (90) calendar days from the date the appeal is received. If the hearing decision is not issued by the 90th day, the waiver service may under specified circumstances be provided until an order is issued.
 9. Waiver services shall continue until an initial hearing decision if the persons supported appeals and requests continuation of waiver services within ten (10) calendar days or five (5) calendar days, as applicable under 42 CFR 431.213-214 and 431.231, of the receipt of the notice of action to suspend or reduce ongoing waiver services. If the denial decision is sustained by the hearing, recovery procedures may be instituted against the persons supported to recoup the cost of any waiver services furnished solely by reason of the continuation of services due to the appeal.
- Notices of Fair Hearing that are required by 42 CFR §431.210, are maintained by the State entity (either TennCare or DIDD) that is responsible for issuing the notice.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

1. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*



No. This Appendix does not apply

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

Operation of Grievance/Complaint System. *Select one:*

- No. This Appendix does not apply
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system: Bureau of TennCare and the Department of Intellectual and Developmental Disabilities (DIDD).

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

Resolution of complaints:

The majority of complaints that are unable to be resolved with the provider agency are filed directly with DIDD. In the event that persons supported, family members and/or legal representatives do not agree with a provider's proposed solution to a complaint, they may contact the DIDD Regional Complaint Resolution Coordinator for assistance. The DIDD Regional Complaint Resolution Coordinator will:

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

In the event the person filing the complaint is not satisfied with the outcome or if a complaint is filed directly with TennCare, the complaint will be referred to the LTSS Quality and Administration Director of ID/DD Services or designee. A complaint is any allegation or charge against a party, an expression of discontent, or information as it pertains to wrong doing affecting the well-being of a person supported. All complaints will be maintained on a complaint log. Each HCBS waiver will have a separate log. Entries to the complaint log will include the following elements:

1. The name of the waiver participant(s)
2. Social security numbers of the participant(s) (if not available from the complainant, to be retrieved from the InterChange System)
3. The name and phone number of the individual reporting the complaint
4. The nature of the complaint(s) or problem(s)

5. The date the Department of Intellectual and Developmental Disabilities (DIDD) was notified of the complaint. If the complainant expressly requests that DIDD not be notified, the reason must be documented.

6. If the complaint is such that appeal rights are involved, documentation that the complainant was informed of such rights.

7. If appeal is requested by the complainant, documentation of the date of referral to the appropriate entity with request for a copy of the final directive.

8. Any actions taken to research, investigate, or resolve the complaint or problem, including dates of such action

9. The results of complaint investigations, including complaints that were validated and a general description of actions taken to resolve complaints (e.g., Corrective Action Plans)

Upon receiving a complaint, designated TennCare staff will determine from the complainant any provider or DIDD staff involved in resolving the issue prior to the complainant's contact with TennCare and the extent to which prior DIDD or provider actions have been successful in resolving the problem. If the complainant indicates that DIDD has been notified of the complaint/problem and has not responded timely or satisfactorily, TennCare staff will contact the appropriate DIDD staff by telephone within two (2) business days (unless requested not to do so by the complainant) to advise of the nature of the complaint and request that all information pertaining to the complaint be provided within five (5) business days, including any actions taken to resolve the complaint or problem as of the date of the contact.

A follow-up memo will be sent to DIDD via fax or mail to document the date of DIDD notification, the request for related DIDD information, and the expected date of receipt.

DIDD will be required to collect any requested information from involved providers and submit it to the TennCare Division of Long Term Services and Supports. Upon receipt of information regarding DIDD completed actions or anticipated actions, a determination will be made as to whether adequate steps have been or are being taken to resolve the issue.

TennCare and DIDD will work cooperatively to achieve complaint resolution. Once TennCare and appropriate DIDD staff have agreed on a course of action to resolve the problem, the complainant and any providers involved will be notified in writing of the proposed solution and expected date of resolution. Sufficient follow-up contacts to the complainant and DIDD will be made by TennCare LTSS Quality and Administration staff to determine if the problem has been adequately resolved. DIDD will be responsible for providing adequate follow-up documentation as requested by TennCare Waiver staff to document that the agreed upon actions were completed. All complaints filed with TennCare are expected to be resolved within 30 calendar days. DIDD will be required to provide written notification of complaint resolution to designated TennCare staff for and will be required to advise TennCare of any TennCare complaints for which resolution cannot be achieved within targeted timeframes. TennCare will continue to monitor remedial actions until it is determined that the problem is resolved and the complaint can be closed. Outstanding complaint cases will be discussed at the monthly TennCare/DIDD meetings.

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

DIDD Complaint Resolution System

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

DIDD service providers are required to establish a complaint resolution system and inform persons supported and or their legal representative of this system and allow easy access when seeking assistance and answers for concerns and questions about the care being provided. Upon admission and periodically, DIDD service providers are required to notify each person supported and or their legal representative of their Complaint Resolution System, its purpose and the steps involved to access it. Providers are asked to resolve all complaints in a timely manner, and within 30 calendar days of the date that the complaint was filed. In the event that a person supported and or their legal representative does not agree with a provider's proposed resolution to a complaint, they may contact the DIDD Complaint Resolution Unit for assistance. The DIDD Regional Complaint Resolution Coordinator will subsequently contact the provider(s) and or other party(ies) involved to discuss potential resolutions to the complaint. This could include formal mediation or intervention meetings. Additionally, independent support coordinators/case managers are required to notify individuals of their rights, including how to file a complaint, an explanation of their appeal rights and the process for requesting a fair hearing, upon enrollment into a waiver program.

Filing a complaint does not void an individual's right to request a fair hearing in accordance with 42 CFR Part 431, Subpart E, nor is it a prerequisite for a fair hearing.

DIDD collects information regarding waiver participant familiarity with the complaint process through the participant satisfaction survey. Information collected is compiled and reported to TennCare in monthly data files and the Quality Management Report. DIDD also reports monthly DIDD complaint data, including the number and type of complaints received, referral sources, remedial actions, and timeframes for achieving resolution. TennCare monitors DIDD complaint remedial actions on a monthly basis and advises DIDD of any that require further action.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. Select one:

- Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)

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

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

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

If a provider reports an allegation of abuse, neglect or exploitation, they are required by State law to contact the appropriate authorities such as Adult Protective Services, Child Protective Services or law enforcement.

Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Participants and their families or legal representatives are provided the DIDD Family Resource Guide which includes information on how to report abuse, neglect, and exploitation to DIDD. The document is also posted on the DIDD website.

DIDD provides ongoing training for providers which include information on how to identify and who to contact when there is an allegation of abuse, neglect or exploitation. Providers use information from this training to educate persons supported and family members upon admission into their services. The Independent Support Coordinator is in regular contact with the person and their family and available to provide information should the need arise.

Additional information is also provided via posters and signs which are visibly posted and which outline the same practices taught in the original training. Finally, training is also provided on an as requested basis.

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

The DIDD Protection From Harm Unit receives allegations of abuse, neglect, exploitation, serious injuries of unknown cause and suspicious deaths. All such incidents are investigated by trained DIDD investigators who interview the participant, service provider, and all available witnesses. The DIDD investigators examine the incident scene and collect other available relevant circumstantial evidence (written statements, expert medical opinions as needed, etc.). Based on the preponderance of the cited evidence, each allegation is determined to either be substantiated or unsubstantiated, and a formal written Investigation Report is generally completed within 30 calendar days of the allegation being witnessed or discovered. (In some extraordinary situations, such as a pending criminal investigation, the DIDD investigation may take longer than 30 calendar days. DIDD requires the waiver service provider to

develop and implement a written management plan that addresses the issues and conclusions specified in the DIDD Investigations report within 14 calendar days of the completion of the Investigation Report. For all other “Reportable Incidents”, DIDD requires the person witnessing or discovering the incident to ensure that a written incident report form is forwarded to the responsible waiver service provider and to DIDD. The service provider is required by DIDD to have incident management processes and personnel in place sufficient to review and respond to all “Reportable Incidents”. The service provider is required to ensure that the incident and the initial response to the incident are documented on the incident report form, to review all provider incidents are reviewed immediately and discussed during biweekly meetings for the purpose of identifying any additional actions needed, and to organize all incident information in a way that would facilitate the identification of at-risk participants as well as other trends and patterns that could be used in agency-level incident prevention initiatives.

The relevant parties of an investigation are notified of the results of an investigation via the following:

1. DIDD will send a final DIDD Investigation Report, as well as, a DIDD Summary of Investigation Report to the Executive Director and when applicable, to the Chair of the Board of Directors of the provider(s) responsible for the person(s) supported involved.
2. The DIDD Summary of Investigation Report will be sent to the support coordination provider/DIDD case manager for all persons supported involved in the incident.
3. The provider will be expected to document reasonable attempts to notify alleged perpetrator(s) of the outcome of the investigation.
4. Within fifteen (15) business days of receipt of the DIDD Summary of Investigation Report, the summary shall be discussed with the person(s) supported involved to the extent possible (if a legal representative has been appointed, the legal representative shall be invited to participate), with such discussion conducted by a representative of the provider who supports the person. The provider will document the date and time of this discussion and the efforts to coordinate the meeting with the legal representative, as applicable.

Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Intellectual and Developmental Disabilities (DIDD) is the agency responsible for overseeing the reporting of and response to all “Reportable Incidents”.

Investigation reports involving allegations of abuse, neglect, or exploitation are reviewed by the DIDD Director of Investigations and are available for review by the Bureau of TennCare.

All “Reportable Incidents” received by DIDD are reviewed for completeness of information (with follow-up for more information if needed), are categorized according to written criteria, and are entered into an electronic database. This database provides data management capabilities including the ability to:

1. Generate “alerts” of individual incidents to designated DIDD staff for follow-up as needed;
2. Support reporting to external entities (e.g., TennCare); and
3. Support internal DIDD trends analysis and reporting functions such as:
 - a. Identification of at-risk participants;

- b. Identification of employees or contract staff with multiple episodes of substantiated abuse, neglect, and exploitation allowing voluntary screening of prospective employees by service providers during the hiring process;
- c. Identification of at-risk situations (e.g., data on injuries from falls);
- d. Creating a detailed profile of identified service providers, with information about reportable incidents related to that provider, and for comparison between service providers; and
- e. Distribution of monthly reports to DIDD management and other staff.

All Incident and Investigation reports completed by DIDD are available for TennCare review. Monthly data files and Quality Management Reports are submitted to TennCare containing information about the number and types of critical incidents reported, the number of investigations initiated and completed, the number and percentage of substantiated allegations, and time frames for completion of investigations. TennCare reviews incident and investigation data to ensure appropriate and timely remediation of identified findings. TennCare notifies DIDD, on a monthly basis, of any investigation findings that are not acceptably remediated. DIDD is required to provide additional information and/or take additional remedial action until TennCare can determine that appropriate remediation has taken place.

Appendix G: Participant Safeguards

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

Use of Restraints. (*Select one*): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

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

The use of seclusion is prohibited. Restraints, including chemical restraints, may be used only when necessary to protect the participant or others from harm and when less intrusive methods have been ineffective. Take downs and horizontal restraint are prohibited. The following mechanical restraints are prohibited: restraint vest, camisoles, body wrap, devices that are used to tie or secure a wrist or ankle to prevent movement, restraint chairs or chairs with devices that prevent movement, and removal of a person's mobility aids such as a wheelchair or walker.

Staff are required to use positive proactive and reactive strategies for preventing and minimizing the intensity and risk factors presented by an individual's behavior whenever possible in order to minimize the use of personal and mechanical restraint.

Emergency personal restraint, mechanical restraint, or emergency medication (chemical restraint) is used only as a last resort to protect the person or others from harm. The use of emergency personal

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

In cases where a behavior analyst assesses the level of behavior need and risk factors and the planning team concurs, the use of personal or manual restraint may be specified as an intervention in a behavior support plan that is reviewed and approved by a Behavior Support Committee and a Human Rights Committee. Informed consent must be obtained from the participant or the participant's guardian/conservator. Such use of restraint must be justified as a necessary component of the least restrictive, most effective behavioral intervention. The use of personal or mechanical restraint is limited to the time period during which it is absolutely necessary to protect the individual or others and is not permitted as a punishment by staff, for staff convenience, or in lieu of person-centered programmatic services. Provider staff who are responsible for carrying out the behavior support plan must be trained on the plan prior to implementation.

Emergency use of personal restraint or mechanical restraint constitutes a reportable incident and as such must comply with DIDD reporting procedures. The case manager must be notified of each use of emergency personal or mechanical restraint within 1 business day.

The use of a psychotropic medication requires a formal diagnosis and informed consent from the persons supported or their legal representative. In addition, the use of psychotropic medications requires review by a human rights committee. When emergency psychotropic medications are administered pursuant to physician's orders, a Reportable Incident Form must be completed and submitted.

Agencies must provide staff training in the area of proactive and reactive supports and restraints adequate to support individuals for whom they are responsible. Quality Assurance standards require that training in an approved personal safety system is provided for each staff member. Five personal safety systems have been approved for use by DIDD agencies that serve persons who are prone to behavioral or psychiatric crises. Agencies are required to show proof of this training during QA surveys.

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

The Department of Intellectual and Developmental Disabilities (DIDD) is the state agency responsible for overseeing the use of restraints and ensuring that safeguards concerning their use are followed. Each month the Behavior Services Director in the DIDD Regional Office reviews a sample of behavior support plans for proper design and implementation and the application of restraints. Regional Office reviews are forwarded to the DIDD Director of Behavior and Psychological Services for analysis. Restraint use is reported at monthly Quality Management Committee meetings.

Data is reviewed by Regional Office Behavior Analysts daily to identify inappropriate uses of restraint. When inappropriate uses of restraint are identified, appropriate actions are taken. System-wide data regarding the use of restraint are produced and reviewed monthly by DIDD Incident Management staff and the Director of Behavioral and Psychological Services. Hypotheses are developed from reviewing these data, and additional data are collected to test these hypotheses. As appropriate these data are shared with providers to initiate changes in agency systems, or are used by DIDD to inform policy. For example, recent studies indicate persons with profound to moderate intellectual disability are more likely to be restrained than persons with mild intellectual disability. DIDD is continuing to review this

data to determine how it may affect agency requirements and targeted training that may be offered. DIDD also compares restraint rates between agencies to better understand agency operations and to consult regarding procedural adjustments that may be needed.

With regard to detecting unauthorized use of restraints, data is provided to the Regional Office Behavior Analyst daily in the manner of incident alerts. Unauthorized, overuse or inappropriate use of restraints is considered a critical incident and the reporting and oversight procedures are included in Appendix G-1: Response to Critical Events or Incidents. When a critical incident involving unauthorized use of restraints is opened for investigation, the Regional Office PFH Follow Up staff notify the Regional Office Behavior Analyst Department who will conduct follow up as needed. System-wide data regarding the use of restraint are produced and reviewed monthly by DIDD Incident Management staff and the Director of Behavioral and Psychological Services. As appropriate, this data is shared with providers to initiate changes in agency systems, or are used by DIDD to inform policy. DIDD continues to review these data to determine how it may affect agency requirements and targeted training that may be offered. DIDD also compares restraint rates between agencies to better understand agency operations and to consult regarding procedural adjustments that may be needed.

Appendix G: Participant Safeguards

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

2. Use of Restrictive Interventions. *(Select one):*

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

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

Restrictive interventions are only implemented as part of a behavior support plan approved by a Behavior Support Committee and a Human Rights Committee and after informed written consent has been obtained from the person supported or the person's legal representative. The emphasis, however, is placed on developing effective behavior support plans that do not require the use of restrictive interventions. If the use of restrictive interventions is required, such use is reevaluated with the goal of reducing or eliminating the continued use of the intervention as clinical progress permits.

The following types of restricted interventions are permitted:

1. Contingent effort;
2. Escape extinction;
3. Non-exclusion and *exclusion time-out;
4. Negative practice;
5. Contingent use of personal property or freedoms;
6. Delay of meals;

7. *Manual restraint;
8. Overcorrection, positive practice;
9. Response cost;
10. Satiation;
11. Substitution of food/meals;
12. Mechanical restraint;
13. *Protective equipment;
14. Required (forced) relaxation; or
15. Sensory extinction.

*Restraints and protective equipment may be used only when necessary to protect the person supported or others from harm and when less intrusive methods have been ineffective. The application of restraint or protective equipment and exclusionary time-out to a specific location must be implemented carefully to ensure protection from harm and to protect the person's rights.

Behavior support plans including restricted interventions must be written by a DIDD approved Behavior Analyst. In special cases, the behavior analyst may request a variance from current policies given a person's unique needs. A variance must be included in a behavior support plan and must be reviewed and approved by the individual and/or guardian or conservator, the Circle of Support, a Behavior Support Committee and Human Rights Committee, and by the Director of Behavior and Psychological Services. Final authorization must be provided by the Commissioner of the Department of Intellectual and Developmental Disabilities or designee.

The application review and approval process for behavior services providers is managed by the DIDD Director of Behavior and Psychological Services. Behavior analysts must have a graduate degree and a minimum of 12 graduate hours in behavior analysis. Courses must focus upon behavior analysis, rather than more generic topics in the discipline for which the graduate degree was awarded. The courses should address the following issues in applied behavior analysis: ethical considerations in the practice of applied behavior analysis; definitions, characteristics, principles, processes and concepts related to applied behavior analysis; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; behavioral change procedures and systems support.

A DIDD approved behavior analyst must complete DIDD required training courses as specified in the Provider Manual and DIDD Staff Development plan. Once the behavior support plan has been developed by the behavior analyst, direct support staff are required to receive training on the implementation of the behavior support plan prior to working with the person supported.

All incidents involving the use of restraints are reported through the DIDD incident management system. Regional Office Behavior Analysis staff routinely (daily, weekly, monthly, annually) review incident reports to determine inappropriate or excessive use of restraint. When inappropriate or excessive use is identified, Regional Office Behavior Analysts investigate and follow up to ensure appropriate actions are taken to address any emerging problems. Examples of actions that might be taken include encouraging the person's circle of support to discuss retaining the services of a behavior analyst or reviewing an existing behavior support plan to determine what types of adjustments might be appropriate.

Agencies must provide staff training adequate to support individuals under their care. Quality Assurance standards require that training in an approved personal safety system is provided for each staff member. Five personal safety systems have been approved for use by DIDD agencies that serve persons who are prone to behavioral or psychiatric crises. Agencies are required to show proof of this training during QA surveys.

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

The Department of Intellectual and Developmental Disabilities (DIDD) is the state agency responsible for overseeing the use of restrictive interventions and ensuring that safeguards concerning their use are followed.

Each month the Behavior Services Director in the DIDD Regional Office reviews a sample of behavior support plans for proper design and implementation and the application of restrictive interventions. Regional Office reviews are forwarded to the DIDD Director of Behavior and Psychological Services for analysis. Restraint use is reported at monthly Quality Management Committee meetings.

Appendix G: Participant Safeguards

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

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

[blank]

Appendix G: Participant Safeguards

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

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

1. **Applicability.** Select one:

- No. This Appendix is not applicable (do not complete the remaining items)
- Yes. This Appendix applies (complete the remaining items)

2. Medication Management and Follow-Up

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

All waiver service providers employing staff who administer medications to persons supported have ongoing responsibility for monitoring to ensure that medications are correctly administered and that medication administration is appropriately documented in accordance with DIDD requirements. Providers must have written policies and procedures for medication administration and implementation of such policies is evaluated during annual DIDD Provider Performance Surveys. On an ongoing basis, providers are required to report medication variances that have caused, or are likely to cause harm to a person supported. DIDD Regional Office staff receive and review reportable incident forms for completeness and determination of the nature of the incident. DIDD monitors for medication variance trends utilizing data from the Incident and Investigations database.

During DIDD Provider Performance Surveys, DIDD Regional Quality Assurance surveyors review a sample of person's Medication Administration Records to identify potentially harmful practices and to ensure compliance with medication administration documentation requirements. Medication variance reports are also reviewed. Provider medication management policies and practices are reviewed to ensure that:

- a. The Medication Administration Record correctly lists all medications taken by the person supported;
- b. The Medication Administration Record is updated, signed, and maintained in compliance with DIDD medication administration documentation requirements;
- c. All medications are administered in accordance with prescriber's orders;
- d. Medications are administered by medication administration certified staff;
- e. Medications are kept separated for each person supported and are stored safely, securely, and under appropriate environmental conditions.

If a person supported is using a behavior modifying medication(including psychotropic medications, the DIDD Regional Quality Assurance surveyors will determine whether (1) there is documentation of voluntary, informed consent for the use of the medication; (2) the persons supported or the person's family member or guardian/conservator was provided information about the risks and benefits of the medication; and (3) the use of a behavior modifying medication as a restricted intervention was reviewed by Behavior Support and/or Human Rights Committees.

Personnel records are reviewed to ensure that licensed staff who administer medications are appropriately licensed and that unlicensed staff who are permitted by state law to administer medications have documentation of completion of current medication administration certification.

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

DIDD is responsible for oversight of medication management. During annual Provider Performance Surveys, DIDD reviews the person supported Medication Administration Record (MAR) to identify potentially harmful practices and to ensure compliance with documentation requirements. Medication variance reports are reviewed. Personal Records are reviewed to ensure that licensed staff who administer medications are appropriately licensed and that unlicensed staff who are permitted by state law to administer medications have documentation of current medication administration certification. When the DIDD quality assurance surveyors identify potentially harmful medication administration/management practices, the surveyors notify the provider during the survey and then review such issues during the exit conference at the end of the survey. In addition, the provider is notified in writing of any problems identified during the survey, and the provider is required to take

appropriate action to resolve such problems in a timely manner. When deficiencies are identified, the DIDD Regional Director is notified and is responsible for ensuring that DIDD Regional Office staff follow up to verify timely and appropriate resolution.

Providers are required to complete a reportable incident form for medication variances if the variance is category E to I on the Medication Variance Form, and a copy of the DIDD Medication Variance Report is submitted with the RIF. In all cases, medication administration by a person who was not trained and certified, or was not licensed by the State of Tennessee to administer medications requires notification to the DIDD Investigations Hotline. Provider agencies are responsible for identifying medication variance trends. Agencies with systemic performance issues identified regarding medication administration during the annual quality assurance survey are discussed during the monthly State Quality Management Committee Meeting.

Appendix G: Participant Safeguards

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

Medication Administration by Waiver Providers

Provider Administration of Medications. *Select one:*

- Not applicable. (do not complete the remaining items)
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (complete the remaining items)

State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Nurse Practice Act in Tennessee generally prohibits administration of medication by unlicensed individuals. There is, however, a statutory exemption for providers who administer medications to individuals receiving services through the Department of Intellectual and Developmental Disabilities (DIDD). This exemption permits certain unlicensed direct support staff to administer medications after successfully completing medication administration certification developed by DIDD. After completing the training program, the individual may administer medications within specified parameters and in accordance with the prescriber's order; however, the individual is not permitted to administer medications when such administration requires judgment, evaluation, or assessment before the medication is administered. The individual must make a written record of any medication that is administered, including the time and amount taken.

Medication Error Reporting. *Select one of the following:*

• Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

The provider agency is required to complete the approved DIDD incident form used to report all medication variances. This form includes information that specifies the name of the physician notified and the date and time of notification. Medication variances are reported to DIDD. DIDD reviews medication variance reports monthly to determine trends that must be addressed with contracted providers or systemically.

(b) Specify the types of medication errors that providers are required to record:

Providers are required to record a medication variance whenever a medication was given in a way that was not consistent with the prescriber's orders, including the following:

1. Medication was given to the wrong person;
2. Medication was given at the wrong time;
3. Wrong dose of medication was given;
4. Wrong form of medication was given (e.g., tablet instead of liquid form);
5. Wrong medication was given;
6. Medication was given by the wrong route of administration;
7. Failure to give the medication; or
8. Medication was not prepared according to the physician's orders (e.g., was not crushed).

(c) Specify the types of medication errors that providers must report to the State:

A medication variance must be reported if it:

1. Requires intervention and caused, or is likely to cause, the person temporary harm;
2. Caused, or is likely to cause, temporary harm requiring hospitalization;
3. Caused, or is likely to cause, permanent harm to the person;
4. Resulted in a near death event (e.g., anaphylaxis, cardiac arrest); or
5. Resulted in or contributed to the person's death.

• **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The state agency responsible for monitoring the performance of waiver providers in the administration of medications to persons supported Department of Intellectual and Developmental Disabilities (DIDD). Provider Performance Surveys are conducted annually by the DIDD Regional Quality Assurance Units to assess the performance of waiver providers in the administration of medications. All waiver service providers who administer medications to persons supported are subject to Provider Performance Surveys and are monitored annually unless they meet established criteria for reduced frequency of monitoring. During Provider Performance Surveys, DIDD Regional Office nurses serve as consultants to non-nurse surveyors.

The following Quality Assurance Indicators are evaluated during Provider Performance Surveys:

1. Medication variances are reported and addressed in a timely manner.

Compliance with requirements to detect, respond to, and report medication variances in accordance with DIDD policy and procedures is assessed. Surveyors determine if the agency has developed and implemented effective procedures for oversight of medication administration and reporting medication variances.

2. The provider analyzes trends in medication variances and implements prevention strategies.

Monitoring is conducted to assess compliance with the requirement that the agency has policies and procedures in place for tracking and trending medication variances that include implementation of prevention strategies. Reviews are conducted to assess whether the agency has a self-assessment process to review medication administration variance; whether the agency reviews recommendations resulting from monitoring; and whether the agency has implemented corrective action in response to recommendations.

3. The person's record adequately reflects all the medications taken by the person.

Surveyors assess whether current prescriber's orders are present for each medication received by the person supported.

4. Needed medications are provided and administered in accordance with prescriber's orders.

Surveyors assess documentation of medication administration or refusal, identification of medication variances with required action being taken, and monitoring of medication self-administration.

5. Only appropriately certified staff administer medication.

Surveyors assess whether licensed staff who administer medications have a current license, unlicensed staff who administer medications have received appropriate training, whether there has been appropriate delegation of medication administration by a registered nurse, and whether the provider conducts ongoing monitoring of staff administering medications.

6. Medication administration records are appropriately maintained.

Surveyors assess compliance with the requirement that agencies must develop and implement procedures for oversight and completion of the Medication Administration Records. Surveyors also assess compliance with the requirement that providers must maintain information on medication side-effects and that the MAR matches prescription labels and prescriber's orders.

7. Storage of medication ensures appropriate access, security, separation, and environmental conditions.

Surveyors assess the provider's compliance with the requirement that provider medication administration policy address procedures for and monitoring of medication storage and disposal.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

Methods for Discovery: Health and Welfare

The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read

"The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

Sub-Assurances:

Sub-assurance: The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.3. # and % of participant satisfaction survey respondents who reported being treated well by direct support staff. (DIDD People Talking to People Survey question: "Do your support staff treat you well or with respect?") % = # of survey respondents who reported being treated well by direct support staff / total # of waiver participants in the sample who responded to this survey question.
a.i.1. Number and percentage of waiver participants who received medical exams in accordance with TennCare Rules. Percentage = number of waiver participants who had timely medical examinations / total number of waiver participants reviewed.
a.i.11. Number and percentage of waiver participants for whom all critical incidents were reported as noted in the primary record and/or support coordination record. Percentage = number of unduplicated waiver participants for whom all critical incidents noted in the primary record and/or support coordination record were reported/total number of waiver participants in the sample.
a.i.4. Number and percentage of participant satisfaction survey respondents who reported having sufficient privacy. (DIDD People Talking to People Survey question: "Are you satisfied with the amount of privacy you have?") Percentage = # of survey respondents reporting sufficient privacy / total # of participants in the sample who responded to this survey question.

Performance Measure
a.i.9 Number and percentage of completed DIDD Investigations for which abuse, neglect, and/or exploitation was substantiated, by type.
a.i.13. Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause. Percentage = number of deaths of unexplained or suspicious cause / total number of deaths.
a.i.17. Number and percentage of complaints appropriately resolved within 30 days of receipt. Percentage = number of complaints appropriately resolved within 30 days / total number of complaints received.
a.i.2. # and % of participant satisfaction survey respondents who indicated knowledge of how to report a complaint. (DIDD People Talking to People Survey question: “Do you know how to report a complaint?”). Percentage = # of survey respondents able to relate how to report a complaint / total number of waiver participants in the sample who responded to this satisfaction survey question.
a.i.8. Number and percentage of DIDD investigations by critical incident type completed within 30 calendar days. Percentage = number of investigations by critical incident type completed within 30 days / total number of investigations completed during the reporting period.
a.i.19 Number and percentage of Plans of Correction related to substantiated investigations, required to be submitted by DIDD providers, which are accepted by DIDD after review.
a.i.10 Number and Percentage of substantiated investigations, by type, for which corrective actions approved by DIDD were verified to address the critical incident within 45 calendar days of issuance of the investigation report.

Sub-assurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.20 Number and percentage of DIDD providers surveyed who demonstrate regular review of their critical incidents.
a.i.21 Number and percentage of DIDD providers surveyed who demonstrate they are implementing preventive/corrective strategies when applicable.

Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.22 Number and percentage of Behavior Support Plans (BSPs) that comply with State policies and procedures regarding the use of restrictive interventions.
a.i.23 Number and percentage of reported critical incidents not involving use of prohibited restrictive interventions.

Sub-assurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or

inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.24 Number and percentage of DIDD providers who develop and maintain policies and implement practices in accordance with the DIDD Provider Manual and policies that achieve outcomes related to health care management and oversight.

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

Note: a.i.19 - a.i.24 are new performance measures in response to the CMS Modifications released in March 2014. The state is proposing to delete a.i.14.: Deaths of unexplained or suspicious cause for which a substantiated investigation determined the death to be a direct result of abuse, neglect, or exploitation. This information is captured in HWa.i.9 and HWa.i.13. The way HWa.i.14 was written did not work in the monthly reporting period required of performance measures, as the conclusion of the cause of death and the outcome of a related investigation are never available within the same month as the death. Tennessee tracks that specific information, the deaths of unexplained or suspicious causes for which a substantiated investigations is determined to be the cause of a death, via the DIDD Death Review Process.

Performance Measures a.i.1. and a.i.11.: A representative sample of waiver participants will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible to collect data during the following twelve (12) months. For each waiver participant included in the sample, Waiver Individual Record Reviews will be conducted by designated DIDD Regional Office staff. Performance Measures a.i.2. through a.i.4.: Data will be generated by contracted interviewers who complete DIDD People Talking to People Consumer Satisfaction Surveys. Interviewers are trained prior to conducting surveys regarding DIDD policies and procedures for identifying and reporting complaints and incidences of abuse, neglect, and exploitation.

Performance Measures a.i.9, a.i.10., a.i.13., a.i.19, and a.i.23 Data describing reportable critical incidents and investigations is entered on an ongoing basis into the DIDD Incident and Investigation Database. Monthly reports are generated that include data describing critical incidents reported and investigations initiated/completed during the month. This data will be compiled by designated DIDD staff and analyzed and trended monthly, year-to-date, and annually by DIDD Regional and State Quality Management Committees. DIDD also performs death reviews. Waiver service providers are required to report any death that is or may be a Suspicious, Unexpected, or Unexplained Death within four hours of discovery to designated DIDD Regional Office staff who record the circumstances of the death. Within one business day of the date of the death, a Notice of Death form must be completed by the waiver service provider and submitted to the DIDD Regional Director. Upon receipt of a Notice of Death form, the DIDD Regional Director or designee schedules a Preliminary Death Review Committee meeting. Within five business days of receipt of the Notice of Death, the Preliminary Death Review Committee shall perform a preliminary death review to determine if the death was Suspicious, Unexpected, or Unexplained. Any death determined to be Suspicious, Unexpected, or Unexplained shall trigger a DIDD

Investigation, the preparation of a Clinical Death Summary, and a DIDD Death Review. The purpose of a DIDD Death Review is to conduct a comprehensive analysis of the relevant facts and circumstances, including the medical care provided, to identify practices or conditions which may have contributed to the death and to make recommendations, where necessary, to prevent similar occurrences.

Performance Measures a.i.17 and a.i.18.: Complaints filed with TennCare are referred to DIDD for resolution and are tracked on the DIDD Complaint Log. The DIDD Customer Focused Government Unit is responsible for reporting complaint resolution strategies and timeframes required for complaint resolution to the TennCare Complaint Coordinator. Complaints are expected to be resolved within 30 calendar days of referral.

Performance Measures a.i.22 and a.i.24 are reviewed during DIDD Quality Assurance (QA) Surveys. QA Surveys are conducted on 100% of providers annually. A random sample of providers is generated each month.

Methods for Remediation/Fixing Individual Problems

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

Performance Measure a.i.1.: DIDD Regional Office staff will notify the Support Coordinator and any other providers, as applicable, to appropriately facilitate completion of a medical examination, expected within 30 days. Support Coordination and other provider agencies, as applicable, will be held accountable for taking appropriate personnel actions within 30 days to address individual DIDD case manager job performance, including, but not limited to training and retraining, verbal or written warning, suspension or termination. Support Coordination and other provider agencies, as applicable, will be required to report resolution dates to DIDD monthly.

Performance Measures a.i.2.- a.i.4.: When individuals do not know how to report complaints, the interviewer will provide the appropriate information. The DIDD People Talking to People Director (PTP) or designee will contact the waiver participant and/or person assisting the waiver participant who received complaint reporting instruction within 60 days to verify that the person who received information knows how to report complaints and has the appropriate written resources describing reporting processes. On a monthly basis, the DIDD PTP Director will report information regarding the number of survey respondents who did not know how to appropriately report a complaint, as well as education provided and verifications completed, to DIDD Central Office staff responsible for data aggregation. When waiver participants report that they have not been treated well or are dissatisfied with the amount of privacy allowed, the interviewer will determine how circumstances failed to meet expectations, when any specific event/s described happened, and if the waiver participant wants to file a complaint or take other action, such as attending self-advocacy meetings or amending the ISP. Negative responses to participant survey questions will be reported to the DIDD PTP Director within three working days. The DIDD PTP Director will ensure that a complaint is filed, if appropriate and in accordance with the waiver participants wishes. The DIDD People Talking to People Director will track resolution of issues identified, as well as timeframes to achieve resolution. Complaints filed will be resolved in accordance with DIDD complaint resolution processes. DIDD goal is to resolve complaint issues within 30 days. Monthly information about complaints and complaint resolution, including types

of complaint and referral sources, will be reported to DIDD Central Office staff responsible for data aggregation.

Performance Measures a.i.8. through a.i.14.: Individual issues identified during DIDD investigations are reported to involved providers, who are required to respond within 30 days to identify corrective actions to be taken. DIDD Regional Office Investigations Follow-up staff are responsible for verifying that appropriate corrective actions were completed within 45 days of issuance of the investigation findings. Investigations results and follow-up actions will be reported monthly to DIDD Central Office staff responsible for data aggregation. DIDD Death Reviews are conducted within 45 business days of the individuals death; however, the time period may be extended by the DIDD Deputy Commissioner for good cause. The Regional Death Review Committee conducts a Death Review of any death determined to be Suspicious, Unexpected, or Unexplained and prepares detailed minutes including conclusions and recommendations for corrective actions. DIDD Regional Office staff ensure that the appropriate providers receive copies of the Committees conclusions and recommendations. DIDD Regional Office Staff verify whether provider corrective actions are appropriately implemented within 45 days of the date the written conclusions/recommendations are.

Performance Measure a.i.11.: When unreported critical incidents are identified, the reviewer will immediately contact the appropriate provider to request that a late report be filed within 2 days and will verify that the complaint was actually filed either by observing the completed report and evidence of submission or by verifying receipt of the report with appropriate Regional Office staff. Failure to file timely critical incident reports may result in provider sanctions as specified in the Provider Agreement. The number of unreported critical incidents discovered will be reported by reviewers via entry into a database that is used by DIDD Central Office staff for data aggregation. Both a DIDD monthly Quality Management Reports and data files containing discovery and remediation data are submitted to TennCare.

Performance Measure a.i.19: Providers are required to submit Plans of Correction related to substantiated incidents of Abuse, Neglect, or Exploitation. DIDD reviews and approves those plans. If the plans are not determined to sufficiently address the issues identified in the investigation, DIDD will reject the plan and ask the provider to revise the plan until it is sufficient.

Performance Measure a.i.20 - a.i.21: When providers cannot demonstrate that they regularly review their critical incidents, DIDD issues a finding. When providers cannot demonstrate that they are implementing corrective actions outlined in their Plans of Correction related to substantiated incidents, DIDD will report those instances.

Performance Measure a.i.22: During annual Quality Assurance surveys, DIDD will review behavior support plans (BSPs) to ensure that they comply with state policies and procedures related to restrictive interventions.

Performance Measure a.i.23: The number of critical incidents that involve the use of prohibited interventions will be tracked and reported.

Performance Measure a.i.24: When providers are not able to provide evidence of policies and practices that achieve outcomes related to health care management and oversight, DIDD will issue a finding. All findings require remediation within 30 days.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of

waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period

the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

System Improvements

Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State's goal is to maintain a quality improvement system that identifies problems, assesses the scope of the problem and ensures that system redesign strategies proactively address issues statewide. This section addresses the process of determining, developing, and implementing statewide remediation strategies.

Remediation strategies implemented to address issues affecting the quality of services offered in the waiver program are vital. It is equally important to evaluate the scope of the problem, so that broader improvements can address the potential for issues to affect other persons supported. One of the State's remediation strategies includes DIDD Regional and State Quality Management Committee monitoring systems.

Regional Quality Management Committees (RQMC)

Each region has an RQMC meeting at least monthly to review provider performance. The RQMC reviews Quality Assurance surveys, Complaint data, Incident and Investigation data or any other issues warranting attention.

Gathered information is analyzed to:

1. determine the scope of each discovery or remediation problem identified (both isolated and systemic);
2. identify whether additional data is needed for cause of the issue;
3. develop recommendations for remediation / improvement strategies ; and
4. evaluate the effectiveness of improvement strategies previously implemented.

The DIDD RQMC is responsible for monitoring provider level remediation and regional improvement strategies through analysis of performance measure data collected. Provider specific issues / data and Regional analysis will be presented to the SQMC throughout the course of the waiver year through a quality management report.

Statewide Quality Management Committee (SQMC)

The SQMC is comprised of management level staff from the Central Office in addition to Regional Office representation. The SQMC analyzes regional data submitted to identify trends, initiate follow up actions, ensure statewide consistency and maintain oversight of RQMC activities.

During the monthly meetings, a prepared Statewide Quality Management Report containing submitted data from all RQMCs is reviewed. The report contains provider information and data for the previous month along with cumulative year-to-date compliance data.

The SQMC reviews:

1. the analysis performed by RQMC's on monthly, cumulative year-to-date, or annual findings;
2. the appropriateness and adequacy of any improvement strategies recommended;
3. the aggregated data for indications of statewide systemic issues;

The SQMC may also determine improvement strategies for systemic level issues and identify the best process for developing those strategies. Appropriate DIDD staff may be assigned as lead for specific responsibilities.

Remediation data received from the RQMCs on provider performance is collated and produced into a monthly DIDD State Quality Management Report. Designated DIDD Central Office Compliance Unit staff develop the report for CMS assurance and sub-assurance performance measure results. This information is reviewed by DIDD and TennCare.

Statewide Continuous Quality Improvement Committee (SCQI)

The SCQI is comprised of management level staff from DIDD Central Office and senior level staff from TennCare. The purpose of this committee is to ensure TennCare's involvement in the ongoing monitoring of overall waiver performance. This committee meets monthly and is focused on statewide systemic trends and issues. Isolated issues are presented as they relate to the minimum compliance threshold because TennCare and DIDD require a 100% remediation standard. The committee reviews, at a minimum:

1. Systemic remediations,
2. Quality Assurance Summary (performance percentages of all providers by type),
3. Status of providers receiving Mandatory Technical Assistance, and
4. Focused performance measure review.

The goals of the SCQI committee are:

1. Identifying systemic issues through the study of the data,
2. Intervene with appropriate, effective quality improvement strategies,
3. Monitor implementation of quality improvement strategies to ensure prevention of reoccurrence of performance issues, and
4. Brainstorm innovative ideas for continuously improving programs and services.

1. •

System Improvement Activities

Responsible Party(check each that applies):	Frequency of Monitoring and Analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div data-bbox="285 814 643 972" style="border: 1px solid gray; height: 75px; width: 220px; margin-top: 5px;"></div>	<input type="checkbox"/> Other Specify: <div data-bbox="863 814 1221 972" style="border: 1px solid gray; height: 75px; width: 220px; margin-top: 5px;"></div>

• System Design Changes

1. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Performance measures with a compliance percentage below 86% consistently in a quarter (i.e. once every 3 months) are assessed for systemic impact with a Quality Improvement Plan developed and implemented if indicated.

1. Monthly, year-to-date, and annual performance measure data will be monitored during the course of the subsequent months to determine if system redesign strategies employed to address regional and state level performance problems were effective in increasing compliance percentages.
2. The DIDD Program Operations unit is responsible for monitoring and evaluating the effectiveness of provider improvement strategies with input and assistance provided by the SQMC, and oversight from TennCare.
3. Consideration will be given as to whether aggregate data indicates a system-wide issue. Annual recommendations on long term improvement strategies will be made by the DIDD Program Operations unit staff to the SQMC. The appropriate DIDD senior management staff will develop a work plan for those measures to be addressed in the coming year. Appropriate DIDD leadership staff will be responsible for the oversight of implementation of the work plan. Results will be reported to TennCare in monthly SCQI meetings.
4. DIDD posts monthly discovery and remediation data files allowing TennCare to generate Compliance Summary Reports containing information on Individual Record Reviews completed,

percentage of compliance for each performance measure, number of findings remediated, and timeframes required for remediation.

The TennCare Director of Quality and Administration- Intellectual Disabilities Services, with assistance and input from TennCare Long Term Services and Supports division staff, will have responsibility for monitoring and evaluating the effectiveness of improvement strategies specifically applicable to identified systemic issues and TennCare processes.

Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

At least annually, the SQMC will review the information needed to assess waiver quality or whether aspects of the quality improvement system require revision and submit recommendations to TennCare. The SQMC will also consider if existing performance measures are appropriate, if revision or deletion of existing measures should be undertaken, or if new performance measures should be added. This information is provided to TennCare as necessary for consideration.

Monthly State Continuous Quality Improvement Committee (SCQI) meetings are held as an opportunity for a collaborative review between DIDD and TennCare concerning issues related to the overall quality of the HCBS waivers. Included in the agenda of these meetings are the performance data, remediation and validation results for the previous month, results of DIDD quality assurance surveys, and a summary of the actions taken at the previous SQMC. As appropriate, additional areas such as DIDD Protection from Harm, Legal Affairs and Provider Development are discussed.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Intellectual and Developmental Disabilities (DIDD) requires providers receiving \$750,000 or more in aggregate state and federal funds to obtain an independent audit of the organization and to submit copies of the independent audit to the Tennessee Office of the Comptroller and to the DIDD Office of Risk Management and Licensure.

The Independent Audit is an industry standard audit performed by a CPA/accounting firm to verify that the provider's business practices adhere to Generally Accepted Accounting Principles (GAAP). To ensure that auditors are truly independent, a preliminary step to all such audits includes written verification that no conflicts of interest exist between the auditor and the agency or firm being audited.

All provider types are included in the audit requirement. All providers, whether independent or part of a larger organization, are reviewed to ensure compliance with the Independent Audit requirement if they meet the \$750,000 threshold.

DIDD maintains a listing of all providers with "total annual funding" listed (i.e., aggregate state and federal funds). The Fiscal Accountability Review (FAR) unit of the Office of Quality Management

conducts annual on-site reviews of all applicable providers, per DIDD policy, to determine compliance with the Independent Audit requirement. If reviewers find that an Independent Audit has not been completed within the past 12 months, a “finding” is issued and the provider is required to submit a written corrective action plan and, as soon as completed, a copy of the Independent Audit.

B. Financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits:

Utilization Review Process - The Bureau of TennCare conducts utilization reviews of the HCBS waivers for persons with intellectual disabilities to determine compliance with federal and state regulations and waiver requirements. Post-payment claim reviews to ensure that services are appropriately documented and appropriately billed are conducted as part of the utilization review process.

Utilization reviews are conducted according to a predetermined audit schedule for the year. Reviews are conducted in each region of the state, and cover different waiver services each month. The person served` sample is identified by entering the following data into the TennCare Interchange System: 1.) waiver provider number; 2.) dates of service; 3.) procedure code for the review; and 4.) paid status. The process includes a review of the approved service plan with the amount, frequency and duration, review of the billing documents and supporting documentation, and a comparison of all documents to adjudicated claims. Identified inconsistencies are documented and researched. Unsupported and/or inappropriate payments result in recoupment.

Fiscal Accountability Review (FAR) – The DIDD Office of Quality Management, Fiscal Accountability Review (FAR) Unit monitors contracts and conducts onsite reviews. A review of the claims billed is compared to supporting documentation and all discrepancies are noted in a report that is submitted to the contract provider for comment. Recoupment for unsupported charges is made after review of the agency’s comments. The initial report and final resolution is then submitted to TennCare for additional follow up where appropriate.

State of Tennessee, Department of Audit, Audit Manual, Section A-2 - Audits cover at least one fiscal year, 12 months, unless otherwise approved by the Comptroller. The Bureau of TennCare (State Medicaid Agency) is subject to an annual audit as required by the Single Audit Act. The audit includes a random sample of each program and includes the 1915c HCBS waiver programs. Requests for documentation to support paid claims are made directly to selected providers by the Department of Audit and all information is submitted by providers to this Department. At the completion of the audit process, a comprehensive report is submitted to TennCare staff for review and follow-up to insure that findings are not repeated in subsequent years.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

1. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded

and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

Sub-Assurances:

Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.1. Number and percentage of claims that are denied or suspended for incorrect billing codes and service rates. Percentage = number of claims denied or suspended / total number of claims submitted.
a.i.3. # and % of paid claims for services delivered to persons enrolled in the waiver in accordance with the approved ISP and with documentation to support the amount, frequency, and duration of services billed. % = # of paid claims for services delivered to persons enrolled in the waiver in accordance with the ISP and with documentation to support paid claims / total number of claims reviewed.

Sub-assurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or

inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure
a.i.4 Number and percentage of rates approved that are consistent with the approved rate methodology throughout the five year waiver cycle.

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

Note: Performance measure a.i.4 is new, in response to the CMS Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, issued in March 2014.

Performance Measure a.i.3. ("Less than 100% review: Other) DIDD FAR reviewers survey 100% of providers with paid claims in excess of \$750,000 for the previous fiscal year. A sample of 10% of waiver participant records (not to exceed 30 records) is selected for the review of providers with paid claims exceeding \$750,000. For providers with paid claims exceeding \$5 million, the sample size increases to 20% (not to exceed 40 records). Reviewers select their samples which must include a billing period of at least three months of the billing year. TennCare Utilization Review processes focus on providers with paid claims less than \$500,000 per year.

Methods for Remediation/Fixing Individual Problems

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

Performance Measure a.i.1.: The TennCare MMIS system generates a Remittance Advice Report listing the status of all submitted claims, including those approved, those denied, and those suspended. DIDD Administrative Unit staff receive reports following each billing cycle. DIDD must correct errors, based on the reason for denial specified in the report, and resubmit the corrected claims within six months. If the error is not appropriately corrected upon resubmission, the claim will be denied again. Upon second denial of a claim, TennCare will issue a written notice to DIDD indicating that a resubmitted claim was denied and cannot be paid until errors are appropriately corrected. TennCare will provide technical assistance as needed to ensure correction of the error. TennCare will track the number of claims denied multiple times for the same error. If more than two denials are generated for the same claim error, TennCare will send a written notice to DIDD requesting corrective action, which may include procedural changes, staff training, or staff disciplinary actions. DIDD will be required to respond with a written explanation of the corrective actions taken within 30 days of receiving the TennCare request for corrective action. Suspended claims are reviewed by designated TennCare staff for determination of the reasons and appropriateness of suspension. TennCare staff will work toward correction of any issues causing the claim to suspend until they are resolved and result in approval or denial of the claim.

The TennCare MMIS system has edits in place to automatically deny claims that are not consistent with the approved rate methodology. The TennCare Information Systems Unit reports monthly to confirm that no claims have been paid that are inconsistent with that methodology.

Performance Measure a.i.3.: Findings from DIDD FAR reviews are included in an audit report that is sent to the audited provider and copied to the appropriate DIDD, TennCare and Comptroller staff. Repeat findings are identified in the report. Payments made for claims with inadequate or missing information are recouped, unless the provider responds with additional information to justify claims billed.

Providers will be required to submit a management response to DIDD FAR reports within 15 business days. Responses may include additional information to justify billing, agreement with findings and identification of management strategies to improve documentation and billing processes, or a combination of both. For responses not received within 15 business days, the DIDD FAR Director will send a notice advising that the recoupment is due within 30 days and will provide instructions for accomplishing the recoupment. The DIDD FAR Director will track recoupments in a database. At the end of each review period (calendar year), a final reckoning process will be initiated. If recouped amounts have not been collected from the provider, the amount will be withheld from provider payments so that all recoupments for the review cycle are collected no later than the end of the first quarter of the subsequent calendar year (March 31). DIDD FAR reviewers collect information identifying the waiver program in which the waiver participant whose records are being reviewed is enrolled. Consequently, review data is available by waiver program. DIDD reports monthly concerning the number of paid claims and findings if applicable. The FAR Director completes an annual summary regarding collection of recoupments from providers resulting from DIDD FAR findings and submits this to TennCare.

Performance Measure a.i.4: The state will ensure that the rates approved are consistent with the approved rate methodology throughout the five year waiver cycle, and report cases that vary from the approved rate, if applicable.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

Proposed service rates are determined by the Department of Intellectual and Developmental Disabilities (DIDD) and are approved by TennCare, the State Medicaid Agency. The State Medicaid Agency, TennCare, has oversight of the rate determination process. TennCare reviews and approves all rates and keys approved rates into the MMIS for purposes of processing claims for waiver services.

Maximum allowable rates are established for each service based on an analysis of provider costs to deliver services and based on experience, as set forth in DIDD Administrative Rule. Rates must be sufficient to recruit an adequate supply of qualified providers for each service to ensure participants statewide have adequate access to waiver services. In setting rates, the rates for similar services in

other state programs are considered. Providers are reimbursed up to the maximum allowable rate established for a service.

Stakeholders have the opportunity to provide input into the development and sufficiency of rates through the DIDD Statewide Planning and Policy Councils, provider meetings, and other public meetings, as well as through the DIDD rule-making hearing process, which includes public notice and a rule-making hearing. Information about payment rates is made public and is available on the DIDD web site, i.e., TennCare Maximum Reimbursement Rate Schedule.

- **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All Waiver services are prior approved by DIDD. Providers submit invoices for delivered services to the DIDD central office. The DIDD system has numerous edits including an edit that verifies the services provided on the date of service were approved in the participant's ISP.

The DIDD system converts the provider claims that successfully process through all of its edits to the appropriate claim format and submits the claims electronically to TennCare for processing through the MMIS. The MMIS processes the claims, and returns the remittance advices electronically to DIDD and a hard copy to each provider. TennCare issues reimbursement payments to the providers. Providers retain 100% of the payment calculated in the MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

Certifying Public Expenditures (*select one*):

No. State or local government agencies do not certify expenditures for waiver services.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

DIDD approves services in the ISP. All providers submit service invoices to DIDD. The DIDD system validates service invoices against the DIDD approved service plans. The DIDD system creates a claim for services that were in an approved plan and submits the claims to TennCare for processing through the

MMIS. When the claims process through the MMIS, the system checks to verify that the person had an active Pre-Admission Evaluation establishing waiver eligibility, and the person's eligibility for Medicaid on the date of service is verified. Claims are also processed against a number of other edits or audits specific to service limits within the MMIS. Post-payment reviews are conducted by the DIDD Internal Audit Unit and by TennCare to ensure services were provided.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

Method of payments -- MMIS (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

Additional Payment Arrangements

Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a

provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) The Department of Intellectual and Developmental Disabilities (hereinafter "Department" or "DIDD") is a public government organization which delivers health care services to people with intellectual and developmental disabilities who are enrolled in the State's Medicaid waiver. Department employees deliver health care services at the DIDD Regional Resources Centers located in West, Middle, and East Tennessee. The health care services delivered by DIDD employees include behavior services, dental services, nutrition services, occupational therapy, physical therapy, specialized medical equipment, supplies, and assistive technology, and speech language and hearing services. The Department contracts with other qualified providers to furnish other waiver services. All Department employees delivering said health care services, as well as other qualified providers, are required to satisfy waiver requirements regarding qualifications and service standards.

(b) The Department does not require waiver providers to affiliate with the Regional Resource Centers. Waiver providers who elect not to affiliate with the Regional Resource Centers are able to enter into a three-way agreement with the Department and the single State Medicaid Agency (TennCare) through the usual and customary process for direct provider enrollment. A waiver provider's decision on whether or not to agree to contract with the Regional Resource Centers does not have any bearing on the provider's enrollment as a waiver provider.

(c) Waiver participants are not required to secure services through the Regional Resource Centers. When an individual is determined to be likely to require the level of care provided by an ICF/IID, DIDD informs the individual or the individual's legal representative of any feasible alternatives available under the waiver program, including a description of the waiver services and names and addresses of all available qualified providers, and offers the choice of either institutional or waiver services. In addition, individuals are given a Freedom of Choice form which contains a simple explanation of the waiver and waiver services; a statement that participation in the Waiver is voluntary; and notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment. The Freedom of Choice form is explained and the signature of the person to receive waiver services or the legal representative will be obtained on the Freedom of Choice form, which is completed prior to admission into the waiver program.

(d) Any staff person who has direct contact with or direct responsibility for a waiver participant must pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities and must not be listed on the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender List, or the Office of Inspector General List of Excluded Individuals and Entities.

A statewide criminal background check is performed by the Tennessee Bureau of Investigation or a Tennessee-licensed private investigation company. If the staff person has resided in Tennessee for one year or less, a nationwide criminal background check is required in accordance with DIDD requirements. The Bureau of TennCare shall conduct Qualified Provider Reviews of DIDD personnel files to ensure that there is documentation that the mandatory background and registry checks have been conducted on potential staff that will have direct contact with or direct responsibility for waiver participants.

(e) TennCare reviews and approves the final language contained in the three-way provider agreement template which specifies provider requirements and responsibilities as well as DIDD and TennCare

responsibilities in administration/operation of the waiver program. TennCare reviews individual waiver provider and administrative contracts prior to execution and is a signatory on all such contracts. This process assures that OHCDs contracts meet applicable requirements.

(f) Financial accountability is assured through the audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services.

Utilization Review Process - The Bureau of TennCare conducts utilization reviews of the HCBS waivers for persons with intellectual disabilities to determine compliance with federal and state regulations and waiver requirements. Post-payment claim reviews to ensure that services are appropriately documented and appropriately billed are conducted as part of the utilization review process. Utilization reviews are conducted according to a predetermined audit schedule for the year. Reviews are conducted in each region of the state, and cover different waiver services each month. The person sample is identified by entering the following data into the TennCare Interchange System: 1.) waiver provider number; 2.) dates of service; 3.) procedure code for the review; and 4.) paid status. The process includes a review of the approved service plan with the amount, frequency and duration, review of the billing documents and supporting documentation, and a comparison of all documents to adjudicated claims. Identified inconsistencies are documented and researched. Unsupported and/or inappropriate payments result in recoupment.

Contracts with MCOs, PIHPs or PAHPs. *Select one:*

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

Services Furnished in Residential Settings. *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

There are 5 residential services offered through this waiver: Intensive Behavior Residential Services, Supported Living, Residential Habilitation, Medical Residential Services, and Family Model Residential Support. In addition, there are two services that individuals may use on a temporary basis - Behavioral Respite Services and Respite. As per 42 CFR 441.310(a)(2), FFP may be claimed for respite services that are provided in a facility approved by the State. When Respite services are provided in a private residence, room and board costs are excluded from the provider's reimbursement rate.

With the exception of a live-in companion for which the companion's share of room and board costs is allowed, the residential rate structures include only staffing and program costs and exclude all room and board costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Supported Living is the only service in the waiver in which housing and food expenses of an unrelated live-in caregiver will be reimbursed provided that the recipient does not live in the caregiver's home or in a residence that is owned or leased by the provider. The housing and food expenses of the unrelated caregiver will be based on the proportionate share of the household's housing and food expenses.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

- Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	146501.64	4943.03	151444.67	409362.77	4097.20	413459.97	262015.30
2	146501.64	5091.32	151592.96	421643.65	4220.12	425863.77	274270.81
3	146501.64	5244.06	151745.70	434292.96	4346.72	438639.68	286893.98
4	146501.64	5401.38	151903.02	447321.75	4477.12	451798.87	299895.85
5	146501.64	5563.42	152065.06	460741.41	4611.44	465352.85	313287.79

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/ID

Years 1-5: 1923

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was derived from the most recently filed CMS 372 report for the Home and Community-Based Services Waiver for Persons with Mental Retardation (control number 0357) for the period January 1, 2012, through December 31, 2012.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

3. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Twelve month actual participant expenditure data from DIDD formed the basis of estimates of participant utilization and average number of units per user by type of service.

The State will serve the lesser of the number of unduplicated users specified for each year of the waiver or the number it is able to serve with funds appropriated for the DIDD by the legislature each year.

Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The basis for Factor D' was derived from the average per capita acute medical costs for this waiver population reported on the most recently filed CMS Form 372 report for this waiver (control number 0357) for the year which ended 12/31/12. This data was trended forward for each year of the waiver, anticipating a 3% rate of inflation.

Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The basis for Factor G was derived from the annualized average per diem cost of public ICF/IID services as determined by the Tennessee Office of the Comptroller. This data was trended forward for each year of the waiver, anticipating a 3% rate of inflation.

Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The basis for Factor G' was derived from the average per capita acute care expenditures for the institutionalized population as reported on the most recently filed CMS Form 372 report for this waiver (control number 0357) for the year which ended 12/31/12. This data was trended forward for each year of the waiver, anticipating a 3% rate of inflation.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Residential Habilitation
Respite
Support Coordination
Nursing Services
Nutrition Services
Occupational Therapy
Physical Therapy
Specialized Medical Equipment and Supplies and Assistive Technology
Speech, Language, and Hearing Services
Behavior Services
Behavioral Respite Services

Waiver Services
Dental Services
Employment and Day Services
Environmental Accessibility Modifications
Family Model Residential Support
Individual Transportation Services
Intensive Behavioral Residential Services
Medical Residential Services
Orientation and Mobility Services for Impaired Vision
Personal Assistance
Personal Emergency Response System
Semi Independent Living
Supported Living
Transitional Case Management

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

4. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

[Charts for years 1-5 attached on the following pages]

Waiver Services	
Individual Transportation Services	
Intensive Behavioral Residential Services	
Medical Residential Services	
Orientation and Mobility Services for Impaired Vision	
Personal Assistance	
Personal Emergency Response System	
Semi Independent Living	
Supported Living	
Transitional Case Management	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						4893525.00
Residential Habilitation Special Needs Adjustment	Day	30	295.00	30.00	265500.00	
Residential Habilitation	Day	67	300.00	230.25	4628025.00	
Respite Total:						30042.80
Respite Sitter	15 Minutes	1	280.00	3.76	1052.80	
Respite Overnight	Day	10	13.00	223.00	28990.00	
Support Coordination Total:						5378323.32
Support Coordination	Month	1923	12.00	233.07	5378323.32	
Nursing Services Total:						10700650.00
RN	15 Minutes	4	250.00	8.50	8500.00	
LPN	15 Minutes	170	10500.00	5.99	10692150.00	
Nutrition Services Total:						378445.00
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment and Plan Development	Visit	165	1.00	243.00	40095.00	
Other Service	Visit	670	5.00	101.00	338350.00	
Occupational Therapy Total:						815940.00
Therapy	15 Minutes	367	105.00	20.00	770700.00	
Assessment and Plan Development	Day	145	1.00	312.00	45240.00	
Physical Therapy Total:						938495.11
Therapy	15 Minutes	367	100.00	24.00	880800.00	
Assessment and Plan Development	Day	187	1.00	308.53	57695.11	
Specialized Medical Equipment and Supplies and Assistive Technology Total:						52500.00
Specialized Medical Equipment and Supplies and Assistive Technology	Item	35	1.00	1500.00	52500.00	
Speech, Language, and Hearing Services Total:						938868.00
Assessment and Plan Development	Day	232	1.00	299.00	69368.00	
Other Service	15 Minutes	500	94.00	18.50	869500.00	
Behavior Services Total:						5203493.75
Behavior Analyst	15 Minutes	850	314.00	18.85	5031065.00	
Behavior Specialist	15 Minutes	65	393.00	6.75	172428.75	
Behavioral Respite Services Total:						553739.20
Behavioral Respite Services	Day	40	28.00	494.41	553739.20	
Dental Services Total:						1656000.00
Dental Services	Procedure	1200	20.00	69.00	1656000.00	
Employment and Day Services Total:						31685930.00
Supported Employment	Day	400	60.00	103.12	2474880.00	
Community-Based Day	Day		175.00	89.84	25155200.00	
GRAND TOTAL:					281722656.05	
Total Estimated Unduplicated Participants:					1923	
Factor D (Divide total by number of participants):					146501.64	
Average Length of Stay on the Waiver:					358	

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1600				
Facility-Based Day	Day	800	75.00	57.73	3463800.00	
In-home Day	Day	750	10.00	78.94	592050.00	
Environmental Accessibility Modifications Total:						120000.00
Environmental Accessibility Modifications	Modification	12	1.00	10000.00	120000.00	
Family Model Residential Support Total:						2779465.00
Family Model Residential Support	Day	52	305.00	175.25	2779465.00	
Individual Transportation Services Total:						78715.20
Individual Transportation Services	Day	46	240.00	7.13	78715.20	
Intensive Behavioral Residential Services Total:						2033625.00
Intensive Behavioral Residential Services	Day	15	275.00	493.00	2033625.00	
Medical Residential Services Total:						42250000.00
Medical Residential Services	Day	250	325.00	520.00	42250000.00	
Orientation and Mobility Services for Impaired Vision Total:						16857.05
Other Service	15 Minutes	11	88.00	16.60	16068.80	
Assessment and Plan Development	Day	3	1.00	262.75	788.25	
Personal Assistance Total:						2092910.00
Personal Assistance	15 Minutes	61	9125.00	3.76	2092910.00	
Personal Emergency Response System Total:						1820.00
Installation and Testing	Event	1	1.00	200.00	200.00	
Monitoring	Month	3	12.00	45.00	1620.00	
Semi Independent Living Total:						15491.72
					11135.76	
GRAND TOTAL:					281722656.05	
Total Estimated Unduplicated Participants:					1923	
Factor D (Divide total by number of participants):					146501.64	
Average Length of Stay on the Waiver:					358	

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Semi Independent Living	Month	1	12.00	927.98		
Semi Independent Living Incentive Payment	Episode	1	1.00	2500.00	2500.00	
Semi-Independent Living Transition Payment	Episode	1	1.00	1855.96	1855.96	
Supported Living Total:						169101069.90
Supported Living Special Needs Adjustment	Day	600	325.00	35.00	6825000.00	
Supported Living	Day	1477	345.00	318.46	162276069.90	
Transitional Case Management Total:						6750.00
Transitional Case Management	Episode	5	1.00	1350.00	6750.00	
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						4893525.00
Residential Habilitation Special Needs Adjustment	Day	30	295.00	30.00	265500.00	
Residential Habilitation	Day	67	300.00	230.25	4628025.00	
Respite Total:						30042.80
Respite Sitter	15 Minutes	1	280.00	3.76	1052.80	
Respite Overnight	Day	10	13.00	223.00	28990.00	
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Coordination Total:						5378323.32
Support Coordination	Month	1923	12.00	233.07	5378323.32	
Nursing Services Total:						10700650.00
RN	15 Minutes	4	250.00	8.50	8500.00	
LPN	15 Minutes	170	10500.00	5.99	10692150.00	
Nutrition Services Total:						378445.00
Assessment and Plan Development	Visit	165	1.00	243.00	40095.00	
Other Service	Visit	670	5.00	101.00	338350.00	
Occupational Therapy Total:						815940.00
Therapy	15 Minutes	367	105.00	20.00	770700.00	
Assessment and Plan Development	Day	145	1.00	312.00	45240.00	
Physical Therapy Total:						938495.11
Therapy	15 Minutes	367	100.00	24.00	880800.00	
Assessment and Plan Development	Day	187	1.00	308.53	57695.11	
Specialized Medical Equipment and Supplies and Assistive Technology Total:						52500.00
Specialized Medical Equipment and Supplies and Assistive Technology	Item	35	1.00	1500.00	52500.00	
Speech, Language, and Hearing Services Total:						938868.00
Assessment and Plan Development	Day	232	1.00	299.00	69368.00	
Other Service	15 Minutes	500	94.00	18.50	869500.00	
Behavior Services Total:						5203493.75
Behavior Analyst	15 Minutes	850	314.00	18.85	5031065.00	
Behavior Specialist	15 Minutes	65	393.00	6.75	172428.75	
Behavioral Respite Services Total:						553739.20
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Respite Services	Day	40	28.00	494.41	553739.20	
Dental Services Total:						1656000.00
Dental Services	Procedure	1200	20.00	69.00	1656000.00	
Employment and Day Services Total:						31685930.00
Supported Employment	Day	400	60.00	103.12	2474880.00	
Community-Based Day	Day	1600	175.00	89.84	25155200.00	
Facility-Based Day	Day	800	75.00	57.73	3463800.00	
In-home Day	Day	750	10.00	78.94	592050.00	
Environmental Accessibility Modifications Total:						120000.00
Environmental Accessibility Modifications	Modification	12	1.00	10000.00	120000.00	
Family Model Residential Support Total:						2779465.00
Family Model Residential Support	Day	52	305.00	175.25	2779465.00	
Individual Transportation Services Total:						78715.20
Individual Transportation Services	Day	46	240.00	7.13	78715.20	
Intensive Behavioral Residential Services Total:						2033625.00
Intensive Behavioral Residential Services	Day	15	275.00	493.00	2033625.00	
Medical Residential Services Total:						42250000.00
Medical Residential Services	Day	250	325.00	520.00	42250000.00	
Orientation and Mobility Services for Impaired Vision Total:						16857.05
Other Service	15 Minutes	11	88.00	16.60	16068.80	
Assessment and Plan Development	Day	3	1.00	262.75	788.25	
Personal Assistance Total:						2092910.00
GRAND TOTAL:					281722656.05	
Total Estimated Unduplicated Participants:					1923	
Factor D (Divide total by number of participants):					146501.64	
Average Length of Stay on the Waiver:					358	

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance	15 Minutes	61	9125.00	3.76	2092910.00	
Personal Emergency Response System Total:						1820.00
Installation and Testing	Event	1	1.00	200.00	200.00	
Monitoring	Month	3	12.00	45.00	1620.00	
Semi Independent Living Total:						15491.72
Semi Independent Living	Month	1	12.00	927.98	11135.76	
Semi Independent Living Incentive Payment	Episode	1	1.00	2500.00	2500.00	
Semi-Independent Living Transition Payment	Episode	1	1.00	1855.96	1855.96	
Supported Living Total:						169101069.90
Supported Living Special Needs Adjustment	Day	600	325.00	35.00	6825000.00	
Supported Living	Day	1477	345.00	318.46	162276069.90	
Transitional Case Management Total:						6750.00
Transitional Case Management	Episode	5	1.00	1350.00	6750.00	
GRAND TOTAL:					281722656.05	
Total Estimated Unduplicated Participants:					1923	
Factor D (Divide total by number of participants):					146501.64	
Average Length of Stay on the Waiver:						358

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						4893525.00
					265500.00	
GRAND TOTAL:					281722656.05	
Total Estimated Unduplicated Participants:					1923	
Factor D (Divide total by number of participants):					146501.64	
Average Length of Stay on the Waiver:						358

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Special Needs Adjustment	Day	30	295.00	30.00		
Residential Habilitation	Day	67	300.00	230.25	4628025.00	
Respite Total:						30042.80
Respite Sitter	15 Minutes	1	280.00	3.76	1052.80	
Respite Overnight	Day	10	13.00	223.00	28990.00	
Support Coordination Total:						5378323.32
Support Coordination	Month	1923	12.00	233.07	5378323.32	
Nursing Services Total:						10700650.00
RN	15 Minutes	4	250.00	8.50	8500.00	
LPN	15 Minutes	170	10500.00	5.99	10692150.00	
Nutrition Services Total:						378445.00
Assessment and Plan Development	Visit	165	1.00	243.00	40095.00	
Other Service	Visit	670	5.00	101.00	338350.00	
Occupational Therapy Total:						815940.00
Therapy	15 Minutes	367	105.00	20.00	770700.00	
Assessment and Plan Development	Day	145	1.00	312.00	45240.00	
Physical Therapy Total:						938495.11
Therapy	15 Minutes	367	100.00	24.00	880800.00	
Assessment and Plan Development	Day	187	1.00	308.53	57695.11	
Specialized Medical Equipment and Supplies and Assistive Technology Total:						52500.00
Specialized Medical Equipment and Supplies and Assistive Technology	Item	35	1.00	1500.00	52500.00	
Speech, Language, and Hearing Services Total:						938868.00
Assessment and Plan Development	Day	232	1.00	299.00	69368.00	
GRAND TOTAL:					281722656.05	
Total Estimated Unduplicated Participants:					1923	
Factor D (Divide total by number of participants):					146501.64	
Average Length of Stay on the Waiver:					358	

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Other Service	15 Minutes	500	94.00	18.50	869500.00	
Behavior Services Total:						5203493.75
Behavior Analyst	15 Minutes	850	314.00	18.85	5031065.00	
Behavior Specialist	15 Minutes	65	393.00	6.75	172428.75	
Behavioral Respite Services Total:						553739.20
Behavioral Respite Services	Day	40	28.00	494.41	553739.20	
Dental Services Total:						1656000.00
Dental Services	Procedure	1200	20.00	69.00	1656000.00	
Employment and Day Services Total:						31685930.00
Supported Employment	Day	400	60.00	103.12	2474880.00	
Community-Based Day	Day	1600	175.00	89.84	25155200.00	
Facility-Based Day	Day	800	75.00	57.73	3463800.00	
In-home Day	Day	750	10.00	78.94	592050.00	
Environmental Accessibility Modifications Total:						120000.00
Environmental Accessibility Modifications	Modification	12	1.00	10000.00	120000.00	
Family Model Residential Support Total:						2779465.00
Family Model Residential Support	Day	52	305.00	175.25	2779465.00	
Individual Transportation Services Total:						78715.20
Individual Transportation Services	Day	46	240.00	7.13	78715.20	
Intensive Behavioral Residential Services Total:						2033625.00
Intensive Behavioral Residential Services	Day	15	275.00	493.00	2033625.00	
Medical Residential Services Total:						42250000.00
					42250000.00	
GRAND TOTAL:					281722656.05	
Total Estimated Unduplicated Participants:					1923	
Factor D (Divide total by number of participants):					146501.64	
Average Length of Stay on the Waiver:						358

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Residential Services	Day	250	325.00	520.00		
Orientation and Mobility Services for Impaired Vision Total:						16857.05
Other Service	15 Minutes	11	88.00	16.60	16068.80	
Assessment and Plan Development	Day	3	1.00	262.75	788.25	
Personal Assistance Total:						2092910.00
Personal Assistance	15 Minutes	61	9125.00	3.76	2092910.00	
Personal Emergency Response System Total:						1820.00
Installation and Testing	Event	1	1.00	200.00	200.00	
Monitoring	Month	3	12.00	45.00	1620.00	
Semi Independent Living Total:						15491.72
Semi Independent Living	Month	1	12.00	927.98	11135.76	
Semi Independent Living Incentive Payment	Episode	1	1.00	2500.00	2500.00	
Semi-Independent Living Transition Payment	Episode	1	1.00	1855.96	1855.96	
Supported Living Total:						169101069.90
Supported Living Special Needs Adjustment	Day	600	325.00	35.00	6825000.00	
Supported Living	Day	1477	345.00	318.46	162276069.90	
Transitional Case Management Total:						6750.00
Transitional Case Management	Episode	5	1.00	1350.00	6750.00	
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						4893525.00
Residential Habilitation Special Needs Adjustment	Day	30	295.00	30.00	265500.00	
Residential Habilitation	Day	67	300.00	230.25	4628025.00	
Respite Total:						30042.80
Respite Sitter	15 Minutes	1	280.00	3.76	1052.80	
Respite Overnight	Day	10	13.00	223.00	28990.00	
Support Coordination Total:						5378323.32
Support Coordination	Month	1923	12.00	233.07	5378323.32	
Nursing Services Total:						10700650.00
RN	15 Minutes	4	250.00	8.50	8500.00	
LPN	15 Minutes	170	10500.00	5.99	10692150.00	
Nutrition Services Total:						378445.00
Assessment and Plan Development	Visit	165	1.00	243.00	40095.00	
Other Service	Visit	670	5.00	101.00	338350.00	
Occupational Therapy Total:						815940.00
Therapy	15 Minutes	367	105.00	20.00	770700.00	
Assessment and Plan Development	Day	145	1.00	312.00	45240.00	
Physical Therapy Total:						938495.11
Therapy	15 Minutes	367	100.00	24.00	880800.00	
Assessment and Plan Development	Day	187	1.00	308.53	57695.11	
Specialized Medical Equipment and Supplies and Assistive Technology Total:						52500.00
Specialized Medical Equipment and Supplies and Assistive Technology	Item	35	1.00	1500.00	52500.00	
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech, Language, and Hearing Services Total:						938868.00
Assessment and Plan Development	Day	232	1.00	299.00	69368.00	
Other Service	15 Minutes	500	94.00	18.50	869500.00	
Behavior Services Total:						5203493.75
Behavior Analyst	15 Minutes	850	314.00	18.85	5031065.00	
Behavior Specialist	15 Minutes	65	393.00	6.75	172428.75	
Behavioral Respite Services Total:						553739.20
Behavioral Respite Services	Day	40	28.00	494.41	553739.20	
Dental Services Total:						1656000.00
Dental Services	Procedure	1200	20.00	69.00	1656000.00	
Employment and Day Services Total:						31685930.00
Supported Employment	Day	400	60.00	103.12	2474880.00	
Community-Based Day	Day	1600	175.00	89.84	25155200.00	
Facility-Based Day	Day	800	75.00	57.73	3463800.00	
In-home Day	Day	750	10.00	78.94	592050.00	
Environmental Accessibility Modifications Total:						120000.00
Environmental Accessibility Modifications	Modification	12	1.00	10000.00	120000.00	
Family Model Residential Support Total:						2779465.00
Family Model Residential Support	Day	52	305.00	175.25	2779465.00	
Individual Transportation Services Total:						78715.20
Individual Transportation Services	Day	46	240.00	7.13	78715.20	
Intensive Behavioral Residential Services Total:						2033625.00
					2033625.00	
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intensive Behavioral Residential Services	Day	15	275.00	493.00		
Medical Residential Services Total:						42250000.00
Medical Residential Services	Day	250	325.00	520.00	42250000.00	
Orientation and Mobility Services for Impaired Vision Total:						16857.05
Other Service	15 Minutes	11	88.00	16.60	16068.80	
Assessment and Plan Development	Day	3	1.00	262.75	788.25	
Personal Assistance Total:						2092910.00
Personal Assistance	15 Minutes	61	9125.00	3.76	2092910.00	
Personal Emergency Response System Total:						1820.00
Installation and Testing	Event	1	1.00	200.00	200.00	
Monitoring	Month	3	12.00	45.00	1620.00	
Semi Independent Living Total:						15491.72
Semi Independent Living	Month	1	12.00	927.98	11135.76	
Semi Independent Living Incentive Payment	Episode	1	1.00	2500.00	2500.00	
Semi-Independent Living Transition Payment	Episode	1	1.00	1855.96	1855.96	
Supported Living Total:						169101069.90
Supported Living Special Needs Adjustment	Day	600	325.00	35.00	6825000.00	
Supported Living	Day	1477	345.00	318.46	162276069.90	
Transitional Case Management Total:						6750.00
Transitional Case Management	Episode	5	1.00	1350.00	6750.00	
GRAND TOTAL:						281722656.05
Total Estimated Unuplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						4893525.00
Residential Habilitation Special Needs Adjustment	Day	30	295.00	30.00	265500.00	
Residential Habilitation	Day	67	300.00	230.25	4628025.00	
Respite Total:						30042.80
Respite Sitter	15 Minutes	1	280.00	3.76	1052.80	
Respite Overnight	Day	10	13.00	223.00	28990.00	
Support Coordination Total:						5378323.32
Support Coordination	Month	1923	12.00	233.07	5378323.32	
Nursing Services Total:						10700650.00
RN	15 Minutes	4	250.00	8.50	8500.00	
LPN	15 Minutes	170	10500.00	5.99	10692150.00	
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Assessment and Plan Development	Visit	165	1.00	243.00	40095.00	
Other Service	Visit	670	5.00	101.00	338350.00	
Occupational Therapy Total:						815940.00
Therapy	15 Minutes	367	105.00	20.00	770700.00	
Assessment and Plan Development	Day	145	1.00	312.00	45240.00	
Physical Therapy Total:						938495.11
Therapy	15 Minutes	367	100.00	24.00	880800.00	
Assessment and Plan Development	Day	187	1.00	308.53	57695.11	
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies and Assistive Technology Total:						52500.00
Specialized Medical Equipment and Supplies and Assistive Technology	Item	35	1.00	1500.00	52500.00	
Speech, Language, and Hearing Services Total:						938868.00
Assessment and Plan Development	Day	232	1.00	299.00	69368.00	
Other Service	15 Minutes	500	94.00	18.50	869500.00	
Behavior Services Total:						5203493.75
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Behavioral Respite Services Total:						553739.20
Behavioral Respite Services	Day	40	28.00	494.41	553739.20	
Dental Services Total:						1656000.00
Dental Services	Procedure	1200	20.00	69.00	1656000.00	
Employment and Day Services Total:						31685930.00
Supported Employment	Day	400	60.00	103.12	2474880.00	
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Environmental Accessibility Modifications	Modification	12	1.00	10000.00	120000.00	
Family Model Residential Support Total:						2779465.00
Family Model Residential Support	Day	52	305.00	175.25	2779465.00	
Individual Transportation Services Total:						78715.20
GRAND TOTAL:						281722656.05
Total Estimated Unduplicated Participants:						1923
Factor D (Divide total by number of participants):						146501.64
Average Length of Stay on the Waiver:						358

Appendix J: Waiver TN.0357.R03.00 - Jan 01, 2015

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Transportation Services	Day	46	240.00	7.13	78715.20	
Intensive Behavioral Residential Services Total:						2033625.00
Intensive Behavioral Residential Services	Day	15	275.00	493.00	2033625.00	
Medical Residential Services Total:						42250000.00
Medical Residential Services	Day	250	325.00	520.00	42250000.00	
Orientation and Mobility Services for Impaired Vision Total:						16857.05
Other Service	15 Minutes	11	88.00	16.60	16068.80	
Assessment and Plan Development	Day	3	1.00	262.75	788.25	
Personal Assistance Total:						2092910.00
Personal Assistance	15 Minutes	61	9125.00	3.76	2092910.00	
Personal Emergency Response System Total:						1820.00
Installation and Testing	Event	1	1.00	200.00	200.00	
Monitoring	Month	3	12.00	45.00	1620.00	
Semi Independent Living Total:						15491.72
Semi Independent Living	Month	1	12.00	927.98	11135.76	
Semi Independent Living Incentive Payment	Episode	1	1.00	2500.00	2500.00	
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Supported Living	Day	1477	345.00	318.46	162276069.90	
Transitional Case Management Total:						6750.00
Transitional Case Management	Episode	5	1.00	1350.00	6750.00	
GRAND TOTAL:					281722656.05	
Total Estimated Unduplicated Participants:					1923	
Factor D (Divide total by number of participants):					146501.64	
Average Length of Stay on the Waiver:						358