

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.¹ This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Tennessee

B. Waiver Title(s): Statewide Home and Community Based Services (or “Statewide”) waiver
Comprehensive Aggregate Cap Home and Community Based Services (or
"CAC") Waiver
Tennessee Self-Determination Waiver Program

C. Control Number(s): TN-0128.R06.01
TN-0357.R04.01
TN-0427.R03.03

D. Type of Emergency (The state may check more than one box):

<input checked="" type="checkbox"/>	Pandemic or Epidemic
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	National Security Emergency
<input type="checkbox"/>	Environmental
<input type="checkbox"/>	Other (specify):

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state’s mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for

each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

1) Nature of emergency

This Appendix K submission pertains to the COVID-19 pandemic. Tennessee Governor Bill Lee TN Governor issued Executive Order 14 declaring a State of Emergency to facilitate COVID-19 response on March 12, 2020, one day after the World Health Organization officially characterized COVID-19 as a “pandemic” and one day before the declaration of a national emergency by President Trump.

2) Number of individuals affected and the state’s mechanism to identify individuals at risk

This amendment will apply to each of the Section 1915(c) waivers identified above and to all of the approximately 7,150 participants enrolled in these waivers. The COVID-19 emergency poses a unique risk to individuals with Intellectual and Developmental Disabilities (I/DD) served in these programs due to: (1) underlying health conditions; (2) reliance on support from others for activities of daily living; (3) deficits in adaptive functioning that inhibit ability to follow social distancing guidelines and infection control procedures; and (4) receipt of care in shared living arrangements. In addition, many have underlying lung disease, other serious conditions, or are immuno-compromised – which places them at high risk of infection and complications if exposed to COVID-19. To date, there have been eight (8) confirmed positive COVID-19 cases among the participants in these waivers.

3) Roles of state, local and other entities involved in approved waiver operations

Appendix K has been developed and upon approval, will be implemented by TennCare, the Medical Assistance Unit within the Department of Finance and Administration, in collaboration with the Department of Intellectual and Developmental Disabilities, the Operating Agency for these waivers. Upon approval, TennCare will exercise administrative authority and work in partnership with DIDD to determine if and how each of the approved waivers will be implemented in order to assure the health and welfare of waiver participants, and to assure financial accountability and continuity of services and program operations.

4) Expected changes to service delivery methods, if applicable

The requested changes will help to reduce potential risk of exposure and spread of COVID-19 among waiver participants and allow flexibility and support for waiver service providers to accommodate the continued provision of services during the emergency and to ensure stability of the provider network to continue services after the emergency, in order to ensure participants’ health, safety and welfare.

F. Proposed Effective Date: Start Date: March 13, 2020 Anticipated End Date: March 12, 2021

G. Description of Transition Plan.

These temporary flexibilities will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the COVID-19 emergency and for the most part, discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications. With regard to the expanded scope of services for Specialized Medical Equipment and Supplies and Assistive Technology to encompass Enabling Technology, we plan to file an amendment to each of these waivers that will provide for the continuation of this service once the period covered by Appendix K has concluded.

H. Geographic Areas Affected:

Each of these waivers and the populations they serve are statewide, as is the impact of the COVID-19 emergency.

I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:*

The Tennessee Department of Health (TDH) activated its State Health Operations Center (SHOC) on January 16, 2020 to maximize capacity and available resources in preparation to respond to identified COVID-19 cases throughout the State. COVID-19 was designated as a “reportable disease” by TDH later that month, and a Task Force was formed under direction of Governor Bill Lee on March 4, 2020 to enhance Tennessee’s coordinated efforts to prevent, identify, and treat potential cases. A small contingent of the State Emergency Operations Center was activated on March 6, 2020 to respond to COVID-19 operations in the State, and to support TDH. Governor Bill Lee issued Executive Order 14 declaring a State of Emergency to facilitate COVID-19 response on March 12, 2020. The State of Tennessee Emergency Management Plan (TEMP) was activated and the State Emergency Operations Center (SEOC) is at a Level 3– State of Emergency. The Tennessee Emergency Management Agency (TEMA) supports local government needs; anticipates, responds to and remediates life threatening situations; supports the TDH; protects critical infrastructure; and ensures shared situational awareness and unified operations across Tennessee Government. On March 23, Governor Lee established the COVID-19 Unified Command, a joint effort to be led by Finance and Administration Commissioner Stuart McWhorter, to streamline coordination across the TEMA, TDH and Tennessee Department of Military during the COVID-19 emergency.

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state’s response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. X Access and Eligibility:

i. X Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

Applicable only to the Statewide Home and Community Based Services (or “Statewide”) waiver (TN-0128.R06.01) and the Tennessee Self-Determination Waiver Program (TN-0427.R03.03), the COVID+ Residential Special Needs Adjustment (RSNA) and Personal Care Rate Differential (PCRD) shall not be counted against a person supported’s individual cost cap for purposes of determining continued eligibility for the program. A person enrolled in the Statewide waiver (TN-0128.R06.01) or the Tennessee Self-Determination Waiver Program (TN-0427.R03.03) shall not be dis-enrolled if the sole reason the individual cost limit would be exceeded is the temporary rate increases as described in this appendix pertaining to the COVID-19 emergency. Persons supported shall be permitted to exceed the cost limit in order to continue receiving the same type and amount of services before the temporary reimbursement changes went into effect. Except as provided in this section, all other policies applying to the individual cost limit in the Statewide and Self-Determination Waivers shall continue to apply.

ii. ___ Temporarily modify additional targeting criteria.

[Explanation of changes]

b. X Services

i. X Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

iii. ___ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. X Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

Residential habilitation services (i.e., Supported Living, Residential Habilitation, Medical Residential Services, and Family Model Residential), Semi-Independent Living, Personal Assistance, and any other supportive services a person might otherwise receive in the setting where they live (including therapies) may be temporarily provided in alternative community-based settings or locations when necessary to minimize risk of COVID-19 exposure or spread.

Alternative settings may include previously utilized, larger Residential Habilitation dwellings (group homes). There are several of these homes available across the state that we have tentatively planned for use during cases of potential cluster infection or for isolation as needed. This will allow us to continue supports in community settings and avoid institutional placement, while also minimizing the risk of further spread. Additionally, we have contemplated isolation supports in the homes of asymptomatic COVID positive staff who are also supporting persons with a positive diagnosis, and have received offers of availability of space in local churches and community centers as needed.

Utilization of any alternative support location would be under emergency pretense, only because the individual has been displaced due to the COVID-19 emergency. This could include the need for isolation supports due to COVID-19 diagnosis or, potentially, agency or network viability concerns.

In the event the need for emergency support provision in an alternative location occurs, requirement of notification to the Department of Intellectual and Developmental Disabilities (DIDD), at both a Regional Office and Central Office level, has been mandated. This notification must include the physical address of the proposed location, affirmation that all required and approved services can be executed from the proposed location and an attestation as to the physical appropriateness of the dwelling respective to the needs of the proposed recipient of services. Previous to the implementation of services in any alternative location, approval from the DIDD must be provided. To the extent that is available during these crisis situations, any required clinical assessment process will be provided in the alternative location, previous to move, if possible but post move if necessary. As was previously indicated, any decision to provide services in an alternative location will be based on the emergence of a crisis related directly to the health and safety of the person supported.

v. ___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c. ___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.



d. X Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. X Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

Training and qualification changes affect all services provided under the Waivers that include direct assistance to persons supported. The provider type pertaining to these changes is the Waiver Service Provider.

To ensure the onboarding of adequate staffing resources, effective March 13, 2020, during the COVID-19 emergency, the State may modify certain provider training and hiring requirements—specifically those related to training requirements and background checks. These are monitored as part of the State’s Quality Improvement Strategy.

Training is divided into two parts: 1) “Pre-Service” training which must be completed within 30 days of hire and before a person can begin to provide services without another staff or supervisor present; and 2) additional training which must be completed within 60 days of hire (but after the person has begun working). During the PHE, the State wishes to extend the 30-day period to complete pre-service training; however, newly hired staff would still not be permitted to work alone until the pre-service training is completed. Also during the PHE, the State wishes to extend the 60-day period for completion of additional training to up to 120 days from date of hire.

In addition, as it relates to training, additional time may be permitted for renewing CPR and First Aid Certifications from the American Heart Association (AHA), American Red Cross (ARC), and American Health and Safety Institute (ASHI/HSI), or alternative certifications may be accepted.

Medication administration certifications that expire may be extended to allow additional time for certification renewal. Medication administration class to be taught via webinar.

As it relates to background checks, during the PHE, the State is no longer able to complete background checks due to court closures. Pursuant to the Governor’s Executive Order, statutory requirements pertaining to these checks are temporarily waived. Once the PHE is concluded, providers will have 90 days to submit a background check for any employee for whom one has not been completed. However, providers will still be required to perform the following checks *prior to* a staff person providing support:

- Tennessee Department of Health Elderly and Vulnerable Abuse Registry
- Tennessee Felony Offender List (FOIL)
- The Tennessee Sexual Offender Registry
- Office of Inspector General List of Excluded Individuals and Entities (LEIE)

The complete background check must still be completed once the availability of such dispositions resumes, but will not delay the person’s ability to begin providing services in light of current staffing demands and shortages. Once the background check is completed, an employee that does not pass the background check will be terminated in accordance with current policy. Based on the registry checks that are still required to be performed, the State does not anticipate that this will occur in many cases.

ii. ___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii. X Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

Applicable across all three waivers covered by this Appendix K and for all providers of service that require life safety and environmental inspections, licenses which have not received a licensure survey will be placed in "Extended Status" until such time as surveys can be completed. An extension letter will be emailed to each licensee when a license is placed in "Extended Status". Licensure surveys will resume once it is safe to do so in accordance with social distancing expectations. All licenses in "Extended Status" will be completed within six (6) months thereafter.

Risk Management visits to provider agencies have also been suspended, though auditors are available to make visits for any urgent situations which may arise. Risk Management Surveys will also resume once it is safe to do so in accordance with social distancing expectations.

For both licensure surveys and risk management visits, where the extension of the waiver of provider determinations falls outside of the expiration date of the Appendix K, the state will submit either an amended Appendix K or a simple waiver amendment.

e. X Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

During the period of the COVID-19 emergency, level of care evaluations or re-evaluations may be conducted remotely.

f. X Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

HCBS providers are facing severe hardships and without quick financial assistance, some are at risk of closure placing the adequacy of the provider networks in jeopardy. HCBS providers support some of the state's most vulnerable populations. Medicaid is the most significant revenue source for HCBS providers. Most HCBS providers are not well-capitalized and depend on regular cash flow to meet payroll and day-to-day operating expenses.

Certain HCBS providers have been most significantly impacted by the COVID-19 emergency—both in terms of reduced revenues and increased costs of service delivery, including staffing and PPE, regardless of whether any of the persons supported by the provider are confirmed COVID-19 positive. These are providers who deliver in-home support, including residential, personal assistance, and nursing services. These providers are experiencing additional staffing and overtime costs (as staff are not available to provide care due to childcare concerns, illnesses, etc.) and PPE costs.

The intent of these rate increases is to help offset increased staffing, PPE, and other costs related to the COVID-19 pandemic that all providers in these groups are experiencing, and to help ensure the sustainability of the HCBS workforce and provider network.

Residential and personal assistance services are mutually exclusive. A person cannot be authorized to receive both types of service. Nursing is a distinct service provided by a licensed nurse, but may be provided to a person receiving either residential or personal assistance services when the person has skilled nursing needs that can only be performed by a licensed nurse. Except for Medical Residential Services (where nursing is a component of the service specification), nursing services are delivered by a different person (a licensed nurse) and billed separately from any residential or personal assistance service the person might receive.

10% and 30% rate increases (described below) are effective beginning dates of service March 13, 2020 for a two-month period (3/13/20 – 5/12/20).

A 10% temporary rate increase for residential services

- Semi-Independent Living Services (all waivers)
- Supported Living (TN.0128, TN.0357 *only*)
- Residential Habilitation (TN.0128, TN.0357 *only*)
- Family Model Residential (TN.0128, TN.0357 *only*)
- Medical Residential (TN.0128, TN.0357 *only*)
- Behavioral Respite (TN.0128, TN.0357 *only*)

A 30% temporary rate increase for Personal Assistance and Nursing Services

- 30% rate increase for Personal Assistance aligns with CHOICES Personal Care and ECF CHOICES Personal Assistance
- 30% rate increase for Nursing Services aligns with market rate in light of increased demand

20% of the 30% increase is needed to equalize the Personal Assistance rate with the rate being paid for Personal Care Visits in the CHOICES MLTSS program and Personal Assistance in the ECF CHOICES MLTSS program. This allows agencies serving individuals with I/DD in the 1915(c) waivers to offer a more competitive wage as needed to hire staff during the COVID pandemic. 20% of the 30% increase for Nursing services is needed to allow agencies to adjust the pay offered to Nurses to a more competitive wage in order to recruit and retain sufficient staff to deliver needed care during the pandemic.

As a condition of eligibility for the 10% temporary rate increase for residential services and the 30% rate increase for personal assistance and nursing services, the provider must agree to not reduce staff wages/salaries and to use the rate increase to address specific needs related to COVID-19 (which could include paying staff *more*), and commit to continuing service delivery both during and beyond the public health emergency. All COVID-19 related rate increases are subject to audit and recoupment if these conditions are not met.

Among these same provider types on the front lines of delivering HCBS during the pandemic, providers serving individuals confirmed COVID-19 positive are experiencing uniquely severe staff shortages and significantly higher costs to ensure continuity of services for the person in the home and avoid hospitalization, except when medically appropriate. Generally, especially for residential services, the goal is to identify staff who agree to remain in isolation with the person for the duration of the isolation period. It often requires a higher rate of pay to identify staff willing to serve a person who is COVID-19 positive, and considerable additional overtime is also accrued in these circumstances, in addition to a greater need for PPE.

The Residential Special Needs Adjustment (RSNA) and COVID+ Personal Care Rate Differential (PCRD) are specifically intended to reimburse hazard pay to direct support staff, as well as the even higher overtime and PPE costs for services provided to a person confirmed COVID-19+.

In instances where a provider is providing services to a person who is COVID-19 positive, the provider would be eligible to receive *both* the applicable rate increase and the RSNA or PCRD, as applicable. (The RSNA and PCRD payments are mutually exclusive.) Note, however, that the RSNA and PCRD payments are expected to continue through July 24, 2020 (the duration of the PHE declared by the HHS Secretary), subject to the availability of funding approved for these purposes—beyond the period covered by the 10 and 30% rate increases.

COVID+ Residential Special Needs Adjustment (RSNA)

- A per diem add-on payment to the existing residential rate to reimburse hazard pay to direct support staff, as well as overtime and PPE costs for services provided to a person confirmed COVID-19+, including:
 - Semi-Independent Living Services (all waivers)
 - Supported Living (TN.0128, TN.0357 *only*)
 - Residential Habilitation (TN.0128, TN.0357 *only*)
 - Family Model Residential (TN.0128, TN.0357 *only*)
 - Medical Residential (TN.0128, TN.0357 *only*)
 - Behavioral Respite (TN.0128, TN.0357 *only*)

COVID+ Personal Care Rate Differential (PCRD)

- A per unit add-on to the existing unit rate to reimburse hazard pay to direct support staff, as well as overtime and PPE costs for services provided to a person confirmed COVID-19+
 - For purposes of this payment, “Personal Care” includes Personal Assistance and Nursing Services.

The RSNA and the PCRD is based on an increase wage of \$5/hour for hazard pay (reflective of actual provider experience in these circumstances), *in addition to* overtime costs and employer taxes for these higher payments, and higher cost of additional PPE (projected at \$36/day for individuals requiring 24/7 staff and apportioned for RSNAs for individuals requiring less than 24 hours/day paid support and for the per unit PCRD), which will not be included in the overtime calculations.

As a condition of eligibility for the COVID+ RSNA and PCRD payments, the \$5/hour hazard pay must have been made to direct support staff, as supported by payroll records. Payments are subject to audit and adjustment or recoupment if it is determined that the \$5/hour hazard pay was not paid to direct support staff, or the person for which such RSNA or PCRD, as applicable, was billed was not confirmed COVID-19+.

g. X Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

Effective March 13, 2020, during the period of the COVID-19 emergency, Independent Support Coordination (in the Statewide and CAC Waivers) and Self-Determination Waiver Case Management visits may be conducted remotely, using phone or video conferencing solutions in accordance with HIPAA. When either of these responsibilities are completed in place of a required face-to-face meeting, the ISC or SD Case Manager should document the occurrence in a corresponding service note. For ISC and SD Case Manager meetings that require signature sheets, ISCs and CMs should write down people's names (the name of everyone who participates in the meeting) on the signature sheet. The ISC/CM should sign and date the form and identify somewhere on the signature sheet the phone call was held in lieu of a face-to-face meeting due to the COVID 19 emergency. The use of e-signatures that meets privacy and security requirements will be added as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Services may start based on verbal authorization while waiting for the signature to be returned to the case manager, whether electronically or by mail. Signatures will include a date reflecting the ISP meeting date. The State will ensure that the service plan is implemented and that individuals receive services as authorized during the period of the emergency, with the exception of services significantly impacted by state and federal orders and recommendations to practice social distancing (i.e., Community Participation, Employment Services, etc.), which will resume as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

h. X Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

Effective March 18th, 2020; DIDD will track all COVID-19 testing for persons supported. Reporting requirements shall include the reporting of COVID-19 testing for any person supported, regardless of results (positive or negative). The Reportable Event Form (REF) is required to be completed as soon as possible, but no later than by the following business day. The provider completing the REF shall select "Other Type of Event" and specify "COVID-19 Testing" in the space provided. Details of the person's status and test results would be expressed in the narrative section. "COVID-19" needs to be included in the subject line of the REF email. All positive test results shall be reported to the Abuse Hotline (1-888-633-1313) as soon as possible but no later than 4 hours of discovery.

Performance Measure a.i.21 (Number and percentage of DIDD providers surveyed who demonstrate they are implementing preventive/corrective strategies when applicable) will be reviewed off-site via desk review.

i. X Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

Personal, behavioral, and communication supports may be rendered by Personal Assistance and LPN providers in an acute-care hospital or short-term institutional stay when the waiver participant is displaced from home because of COVID-19 and such supports are not otherwise available in these settings.

j. Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k. Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l. Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m. X Other Changes Necessary [For example, any changes to billing processes, use of

contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

All Quality Assurance surveys have been suspended as necessary to accommodate stay-at-home orders or social distancing recommendations. The State will explore the possibilities of reviewing electronic records remotely if providers have the capability to provide them and having entrance and exit conferences by conference call or via WebEx when that is acceptable.

Effective March 13, 2020, Fiscal Accountability Review unit annual reviews can optionally be conducted via off-site review of records (desk review), and this option is extended to all applicable providers that have electronic record systems that allow for the sharing documentation with reviewers.

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

- a. Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

- a. Add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for:
 - i. Case management
 - ii. Personal care services that only require verbal cueing
 - iii. In-home habilitation
 - iv. Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
 - v. Other *[Describe]*:

Nutrition Services, Occupational Therapy, Physical Therapy, Speech, Language, and Hearing Services, Behavior Services, Orientation and Mobility Services for Impaired Vision, Support Coordination, Transitional Case Management, and Semi-Independent Living in accordance with Section A of this Appendix K Addendum: COVID-19 Pandemic Response – NOTE that any components of these services requiring direct evaluation or interactive, hands-on care to be effective and therapeutic shall not be delivered electronically.

- b. Add home-delivered meals
- c. Add medical supplies, equipment and appliances (over and above that which is in the state plan)
- d. Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

- a. Current safeguards authorized in the approved waiver will apply to these entities.
- b. Additional safeguards listed below will apply to these entities.

4. Provider Qualifications

- a. Allow spouses and parents of minor children to provide personal care services
- b. Allow a family member to be paid to render services to an individual.
- c. Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

- d. Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

- a. Allow an extension for reassessments and reevaluations for up to one year past the due date.
- b. Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- c. Adjust prior approval/authorization elements approved in waiver.
- d. Adjust assessment requirements
- e. Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name: Patti
Last Name: Killingsworth
Title: Assistant Commissioner, Chief of LTSS
Agency: Division of TennCare
Address 1: 310 Great Circle Road
Address 2: Click or tap here to enter text.
City: Nashville
State: Tennessee
Zip Code: 37243
Telephone: 615-507-6468
E-mail: Patti.Killingsworth@tn.gov
Fax Number: 615-741-1092

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name: Brad
Last Name: Turner
Title: Commissioner
Agency: Department of Intellectual and Developmental Disabilities
Address 1: UBS Tower, 8th Floor
Address 2: 315 Deaderick Street
City: Nashville
State: Tennessee
Zip Code: 37243
Telephone: 615-532-5970
E-mail: Brad.Turner@tn.gov
Fax Number: 615-532-9940

8. Authorizing Signature

Signature:

Date: 4/30/20

_____/S/_____
State Medicaid Director or Designee

First Name: *Patti*
Last Name *Killingsworth*
Title: Assistant Commissioner, Chief of LTSS
Agency: Division of TennCare
Address 1: 310 Great Circle Road
Address 2: Click or tap here to enter text.
City Nashville
State Tennessee
Zip Code 37243
Telephone: 615-507-6468
E-mail Patti.Killingsworth@tn.gov
Fax Number 615-741-1092

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification

Service Title: **Specialized Medical Equipment and Supplies and Assistive Technology**

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

Service Definition (Scope):

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

- a. An assistive device or adaptive aid or control designed for individuals with special functional needs which:
 - (1) Increases the ability to perform activities of daily living (e.g., adaptive eating utensils and dishware; an adaptive toothbrush); or
 - (2) Increases the ability to communicate with others (e.g., a hearing aid; an augmentative alternative communication device or system; an adaptive phone for individual with visual or hearing impairments); or
 - (3) Increases the ability to perceive or control the environment within the home (e.g., a smoke alarm with a vibrating pad or flashing light); and
- b. A gait trainer; and
- c. A sidelyer or similar positioning device; positioning wedges or rolls or similar positioning items; and
- d. Supplies necessary for the proper functioning of specialized medical equipment or assistive technology covered within the scope of this waiver definition; and
- e. Repair of specialized medical equipment or assistive technology devices covered within the scope of this waiver definition when the repair is not covered by warranty and when it is substantially less expensive to repair the equipment or device than replace it.

Specialized Medical Equipment, Supplies, and Assistive technology shall be medically necessary and shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist).

The following items are excluded from coverage:

- a. Items not of direct medical or remedial benefit to the person supported;
- b. Items covered by the Medicaid State Plan/TennCare Program;
- c. Hearing aids and augmentative alternative communication systems for children under age 21 years;
- d. Eyeglasses, frames, and lenses;
- e. Elevators, stairway lifts, stair glides, platform lifts, stair-climbing devices, electric powered recliners, elevating seats, and lift chairs;
- f. Sensory processing/sensory integration equipment or other items used in sensory integration therapy (e.g., ankle weights, weighted vests or blankets, sensory/therapy balls, swings, vibrators, floor mats, balance boards, brushes, trampolines);
- g. Carpets, rugs, flooring, floor pads and mats; curtains, drapes, and window treatments; furniture, lamps, and lighting;
- h. Beds, mattresses, bedding, and overbed tables;
- i. Air conditioning systems or units, heating systems or units; water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
- j. Electrical generators, electrical service, or emergency electrical backup systems;
- k. Adaptive devices for use with items specifically excluded by this waiver definition;
- l. Recreational or exercise equipment and adaptive devices for such; adaptive tricycles;
- m. Toys, toy equipment, and adaptive devices for toys (e.g., flash switches);
- n. Radios, televisions, or related electronic audiovisual equipment (e.g., DVD players); telephone, television, or internet service; and equipment or items for education, training, or entertainment purposes;
- o. Personal computers; printers, monitors, scanners, and other computer-related hardware and software (excluding equipment designed specifically and primarily to be used as an augmentative alternative communication system for adults);
- p. Orthotics;
- q. Stethoscopes or blood pressure cuffs;
- r. Clothing;
- s. Diapers and other incontinence supplies;
- t. Food, food supplements, food substitutes (including formulas), and thickening agents;
- u. Prescription and over-the-counter medications; vitamins, minerals, and nutritional supplements;
- v. Swimming pools, hot tubs, whirlpools and whirlpool equipment, and health club memberships;
- w. Lifting and tracking systems for transfer of persons supported;

- x. Supplies other than those supplies specifically required for the proper functioning of specialized medical equipment or assistive technology devices that are covered within the scope of this definition;
- y. Duplicate items of specialized medical equipment or assistive technology, excluding adaptive eating utensils and dishware, to provide the person supported with a backup or spare;
- z. Repair of equipment covered by warranty;
- aa. Physical modification of the interior or exterior of a place of residence; and
- bb. Physical modification of a motor vehicle or motor vehicle parts and services, including adaptive devices to facilitate driving.

Specialized Medical Equipment, Supplies and Assistive Technology is not intended to replace services available

through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the Department's policy on submission of bids. If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for the Specialized Medical Equipment, Supplies, and Assistive Technology or the request will be denied.

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

The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

All medically necessary services that are included within the categories of mandatory and optional services listed in section 1905(a) shall be covered under the federal EPSDT program for children under age 21. Items and services beyond the scope of EPSDT but included in the approved definition for Specialized Medical Equipment and Supplies and Assistive Technology may be covered for children under age 21 enrolled in the waiver based on medical necessity.

Effective March 13, 2020, and during the period covered by this Appendix K pertaining to the COVID-19 emergency, the Specialized Medical Equipment and Supplies and Assistive Technology service is expanded to include Enabling Technology.

Enabling Technology is equipment, devices, items and/or their deployment or innovations that, in combination with associated technologies, provides the means to support an individual's increased independence in the home or community. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment, devices or items required by the person to increase, maintain or improve his/her functional capacity to perform daily tasks that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation.

Enabling Technology includes remote support technology systems in which remote caregivers can interact, coordinate supports, or actively respond to needs as appropriate. Remote support systems are real time support systems which include two-way communication.

- These systems use wireless technology, and/or phone lines, to link an individual's home to a person off-site to provide up to 24/7 support.
- These systems include the use of remote sensor technology to send "real time" data remote staff or family who are immediately available to assess the situation and provide assistance according to an individual support plan (ISP).

Examples of Enabling Technologies include (but are not limited to):

- Motion sensors
- Smoke and carbon monoxide alarms
- Bed and/or chair sensors
- Door and window sensors
- Pressure sensors in mats on the floor
- Stove guards
- Live web-based remote supports
- Automated medication dispenser systems
- Software to operate accessories included for environmental control

Enabling Technology also includes monitoring services as needed by an entity external to the Residential or Personal Assistance services provider, using certain of the devices described above and the provision of 24-hour response and assistance as needed to support waiver participants in maintaining independence and assuring health and safety when staff are not physically present.

During the period for which Appendix K is effective, Residential and Personal Assistance providers will sub-contract with the technology supplier/monitoring services business entity.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Specialized Medical Equipment, Supplies, and Assistive Technology (including Enabling Technology) shall be limited to a maximum of \$10,000 per person supported per 2 waiver program years (calendar years).

Service Specification

Service Title: **Semi-Independent Living**

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

Service Definition (Scope):

Semi-Independent Living Services (SILS) shall mean services selected by the person supported that include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene, interpersonal and social skills building, and other activities needed to maintain and improve the capacity of an individual with an intellectual disability to live in the community, and which supports the person's independence and full integration into the community, ensures the person's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual's specific assessed need and set forth in the person-centered Individual Support Plan (ISP).

The service also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The SILS provider shall oversee the health care needs of the person supported.

This service is appropriate for people who need intermittent or limited support to remain in their own home and do not require staff that lives on-site. However, access to emergency supports as needed from the provider on a 24/7 basis is an essential component of this residential service and is what differentiates it from Personal Assistance services.

Individuals receiving SILS may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home. No more than 3 persons receiving services will be permitted per residence. All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

The Circle of Support must consider the person's level of independence and safety prior to establishing a semi-independent living arrangement. Safety considerations must be reviewed at least annually (and more often should a change of needs or circumstances warrant). Consideration regarding the use of a Personal Emergency Response System should be given when appropriate. The ISP must reflect the routine supports that will be provided by residential staff.

The person may choose to live with one or two other persons supported and share expenses or to live alone as long as sufficient financial resources are available to do so.

Reimbursement for SILS shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person(s) supported and other residents in the home (if applicable).

A person who is receiving SILS shall not be eligible to receive Personal Assistance, Respite or Transportation as separate services. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of SILS and shall be included in the reimbursement rate for such.

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

SILS shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/IID). A family member(s) of the person supported shall not be

reimbursed to provide SILS. SILS shall not be provided in a home where a person supported lives with family members unless such family members are also persons receiving waiver services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

On a case-by-case basis, the DIDD Commissioner or designee may authorize SILS for a person supported who resides with his or her spouse and or minor children.

SILS shall not be provided out-of-state.

A minimum of two face-to-face direct service visits in the home per week are required for each person receiving SILS. However, providers delivering this service are required to implement provisions for availability of provider staff on a 24-hour basis in case emergency supports are needed. Only during the period of the COVID-19 emergency, because there is a personal emergency response system in place for this service, providers may complete the minimum service visits by phone or virtually.

SILS providers are required to be licensed as Intellectual Disabilities Semi-Independent Living Providers.

Service Specification

Service Title: **Residential Habilitation - Statewide (TN.0128) and CAC (TN.0357) Waivers only**

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

Service Definition (Scope):

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

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

The Residential Habilitation dwelling shall be licensed by the State of Tennessee.

A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

Individuals receiving Residential Habilitation services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted pursuant to state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports for up to 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work, based on the person's support needs. Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk.

Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.

A person supported who is receiving Residential Habilitation shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Residential Habilitation provider).

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, and in accordance with TennCare protocol, transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such.

Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling. Reimbursement for Residential Habilitation shall not include payment for Residential Habilitation provided by the spouse of a person supported. The Residential Habilitation provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for

Residential Habilitation provided by such individuals. Reimbursement for Residential Habilitation shall not include payment made for services provided by an individual who has been appointed as the conservator of the person supported, unless so permitted in the Order for Conservatorship.

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

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

- a. Out-of-state services shall be limited to a maximum of 14 days per person supported per waiver program year (i.e. calendar year). Effective March 13, 2020, the maximum limit for out-of-state services of 14 days per person supported per calendar year may be extended as necessary during emergency situations impacting a significant portion of the population such as natural disasters or public health emergencies which would require broader use of out-of-state services to ensure continuity and quality of services to persons supported.
- b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
- c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
- d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Residential Habilitation services that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of "homebound" and as a result, is unable (not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time.

'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period. Effective March 13, 2020, during the COVID-19 emergency, due to the chronic nature of the threat of exposure to COVID-19, the homebound definition shall be met on any day when a person does not participate in employment or community activities due to stay-at-home orders and/or social distancing recommendations to prevent risk of exposure and spread of COVID-19. This temporary flexibility will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:

1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.
2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.
3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.
4. Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being. Effective March 13, 2020, during the COVID-19 emergency, this provision shall apply to any person previously receiving services to participate in integrated community employment or community activities (including Employment Supports--Individual or Small Group, Community Participation Supports, and Intermittent Employment and Community Integration Wrap-Around Supports) or previously receiving Facility-Based Day Supports who is unable to continue participation in such activity due to stay-at-home orders and/or social distancing recommendations to prevent risk of exposure and spread of COVID-19. This temporary flexibility will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the individual to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD (e.g., end of life). All individual goals and objectives, and specific needed supports, related to authorization of the RSNA- HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person-centered ISP.

The RSNA-HB can only be authorized and paid for services provided on the same day that Residential Habilitation services are also authorized and provided.

Service Specification

Service Title: **Support Coordination - Statewide (TN.0128) and CAC (TN.0357) Waivers only**

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

Service Definition (Scope):

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

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

Ongoing monitoring by the ISC is accomplished through a stratified approach, based on level of support need, as follows: A person assessed to have level of need 1, 2, or 3 for purposes of reimbursement or not receiving any residential or day service reimbursed based on level of need requires a minimum of at least one monthly in-person or telephone contact and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home. A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires a minimum of at least one monthly face-to-face contact across all environments and in the person's residence at least quarterly. Residential level of reimbursement is the overriding determinant of the contact frequency. Only during the period of the COVID-19 emergency, Independent Support Coordination visits may be conducted remotely, using phone or video conferencing solutions. When either of these responsibilities are completed in place of a required face-to-face meeting, the ISC should document the occurrence in a corresponding service note.

Day services level of need will only determine visit frequency if the person receives no residential services. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ISP for that person per service received across service settings. Generally, face-to-face visits should be coordinated with the person supported (and their family, as applicable) to occur in the person's residence.

However, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home.

Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request, or based on a significant change in needs or circumstances. Information is gathered using standardized processes and tools.

The Support Coordination provider shall initiate and oversee at least annual reassessment of the individual's level of care eligibility, and initial and at least annual assessment of the individual's experience to confirm that

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

Service Specification

Service Title: **Nutrition Services**

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

Service Definition (Scope):

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

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

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

Only during the period of the COVID-19 emergency, Nutrition Services may be provided electronically.

Generally, this means that the person and the provider are connected via an interactive audio and video telecommunications system. However, only the COVID-19 emergency, due to the consultative nature of the benefit, Nutrition Services may be delivered telephonically so long as the therapeutic goals and objective(s) specified in the ISP can be effectively met. Any components of the service requiring direct evaluation and interactive, hands-on care to be effective and therapeutic are excluded. Also only during the COVID-19 emergency, Nutrition Services may unknowingly be provided concurrently due to the nature of the emergency exceptions being granted for electronic means of service provision. For example, one clinical provider may be providing services directly to the individual and another clinical provider may be providing Nutrition Services to the individual through consultation regarding the nutrition plan to a staff or family member.

The unit of reimbursement for a Nutrition Services assessment with plan development shall be per day. The unit of reimbursement for other Nutrition Services shall be per day.

Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one assessment visit per waiver participant (person supported) per waiver program year (calendar year). Nutrition Services other than the assessment (e.g., person supported- specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one visit per day.

Nutrition Services (including Nutrition Services assessments and other non-assessment services) shall be limited to a maximum of six (6) visits per waiver participant (person supported) per waiver program year (calendar year), of which no more than one (1) visit per waiver program year (calendar year) may be an assessment.

Except as provided above during the COVID-19 emergency, a Nutrition Services assessment cannot be billed on the same day with other Nutrition Services. Also except as provided above during the COVID-19 emergency, reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Nutrition Services unless provided by a licensed dietitian or nutritionist.

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

Service Specification

Service Title: **Occupational Therapy**

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

Service Definition (Scope):

Occupational Therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations involving performance of activities of daily living; and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Occupational Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist. Occupational Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Only during the COVID-19 emergency, Occupational Therapy services may be provided via telehealth. Generally, this means that the person and the provider are connected via an interactive audio and video telecommunications system. Any components of the service requiring direct evaluation and interactive, hands-on care to be effective and therapeutic are excluded. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

Occupational Therapy shall be provided in accordance with a treatment plan developed by a licensed occupational therapist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Occupational Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Occupational Therapy services shall require documentation of reassessment of the condition of the person supported and continuing progress of the person supported toward meeting the goals and objectives.

Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Hearing, and Language Services; Orientation and Mobility Services for Impaired Vision, Behavior Services, or except during the COVID-19 emergency, Nutrition Services, unless there is documentation in the person supported has a record of medical justification for the two services to be provided concurrently.

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

The unit of reimbursement for an Occupational Therapy assessment with plan development shall be per day.

The unit of reimbursement for other Occupational Therapy services shall be per 15 minutes.

Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Occupational Therapy services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services. Reimbursement shall not be made for telephone consultations.

A provider shall not receive reimbursement for Occupational Therapy unless provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist

Service Specification

Service Title: **Physical Therapy**

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

Service Definition (Scope):

Physical therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations related to ambulation and mobility; and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Physical Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist. Physical Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Only during the COVID-19 emergency, Physical Therapy services may be provided via telehealth. Generally, this means that the person and the provider are connected via an interactive audio and video telecommunications system. Any components of the service requiring direct evaluation and interactive, hands-on care to be effective and therapeutic are excluded.

Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

Physical Therapy shall be provided in accordance with a treatment plan developed by a licensed physical therapist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Physical Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Physical Therapy services shall require documentation of reassessment of the condition of the person supported and continuing progress of the person supported toward meeting the goals and objectives.

Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language, and Hearing Services; Orientation and Mobility Services for Impaired Vision; Behavior Services; or except during the COVID-19 emergency, Nutrition Services, unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently.

Physical Therapy is not intended to replace services that would normally be provided by direct care staff.

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

The unit of reimbursement for a Physical Therapy assessment with plan development shall be per day. The unit of reimbursement for other Physical Therapy services shall be per 15 minutes.

Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Physical Therapy services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day.

Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Physical Therapy unless provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

Service Specification

Service Title: **Speech, Language, and Hearing Services**

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

Service Definition (Scope):

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

Services must be provided by a licensed speech language pathologist or by a licensed audiologist. Speech, Language, and Hearing Services must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Only during the COVID-19 emergency, Occupational Therapy services may be provided via telehealth. Generally, this means that the person and the provider are connected via an interactive audio and video telecommunications system. Any components of the service requiring direct evaluation and interactive, hands-on care to be effective and therapeutic are excluded.

Speech, Language, and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language, and Hearing assessments (i.e., assess and treat orders are not accepted).

Speech, Language, and Hearing Services shall be provided in accordance with a treatment plan developed by a licensed speech language pathologist or a licensed audiologist based on a comprehensive assessment of the needs of the person supported, and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Speech, Language, and Hearing Services to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Speech, Language, and Hearing Services shall require documentation of reassessment of the person's condition and continuing progress of the person supported toward meeting the goals and objectives. Speech, Language, and Hearing Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Orientation and Mobility Services for Impaired Vision, Behavior Services, or except during the COVID-19 emergency, Nutrition Services, unless there is documentation in the person's record of medical justification for the two services to be provided concurrently.

Speech, Language, and Hearing Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Speech, Language, and Hearing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

The unit of reimbursement for a Speech, Language, and Hearing Services assessment with plan development shall be per day. The unit of reimbursement for other Speech, Language, and Hearing Services shall be per 15 minutes.

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

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

Service Specification

Service Title: **Behavior Services**

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

Service Definition (Scope):

Behavior Services shall mean:

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

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

Behavior Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Orientation and Mobility Services for Impaired Vision, or Speech, Language, and Hearing Services, or except during the COVID-19 emergency, Nutrition Services, unless there is documentation in the person's record of medical justification for the two services to be provided concurrently. Only during the COVID-19 emergency, Behavior Services may be provided via telehealth. Generally, this means that the person and the provider are connected via an interactive audio and video telecommunications system. Any components of the service requiring direct evaluation and interactive, hands-on care to be effective and therapeutic are excluded.

Except as provided above during the COVID-19 emergency, Behavior Services shall be provided by a Behavior Analyst face to face with the person supported except for:

- (a) Completion of the Behavior Assessment Report; and
- (b) Person supported-specific training of staff, except in instances when the Behavior Analyst can demonstrate appropriate interventions in real time; and
- (c) Presentation of behavior information of the person supported at human rights committee meetings, behavior support committee meetings, and planning meetings related to the person supported. Reimbursement for presentation of behavior information related to the person supported at meetings shall be limited to a maximum of 5 hours per person supported per calendar year per provider.

Behavior assessments, behavior plan development, and presentations at meetings shall not be performed by Behavior Specialists. Behavior specialists are responsible for providing training, data collection and plan implementation but only behavior analysts can conduct a behavior assessment and develop the behavior support plan. Reimbursement for behavior assessments shall be limited to a maximum of 8 hours per assessment (32 qtr hour units per calendar year) with a maximum of 2 assessments per calendar year.

Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first 30 calendar days following its approval for use shall be limited to a maximum of 6 hours (24 qtr hour units per calendar year). Reimbursement shall not be made for travel time to meetings or, except during the COVID-19 emergency, for telephone consultations, but may be made for consultations with the treating physician or psychiatrist during an office visit when the person supported is present, or during the COVID-19 emergency, via telehealth.

Reimbursement for presentation of person supported behavior information at human rights committee meetings, behavior support committee meetings, and person supported planning meetings shall be limited to 5 hours per provider (20 qtr hour units per calendar year).

Behavior Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program, including psychological evaluations and psychiatric diagnostic interview examinations.

Behavior Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Service Specification

Service Title:	Family Model Residential Support - Statewide (TN.0128) and CAC (TN.0357) Waivers only
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Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope):

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

In this type of shared living arrangement, the caregiver allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and family, supports each resident’s independence and full integration into the community, ensures each resident’s choice and rights, and supports each resident in a manner that comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual’s specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. Family Model Residential Support includes individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside successfully in a community-based setting, living in a family environment in the home of trained caregivers other than the family of origin. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual’s rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Family Model Residential Supports may include medication administration as permitted under Tennessee’s Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Family Model Residential Support caregiver shall oversee the health care needs of the person supported. The Family Model Residential Support provider agency shall not find, purchase, or lease a residence in which Family Model Residential Supports will be provided. Family Model Residential Support caregivers shall be recruited, screened, contracted, and trained prior to providing services, and monitored by the Family Model Residential Support provider agency to ensure compliance with licensing and program requirements. The Family Model Residential Support provider agency shall facilitate matching of persons supported and caregivers but shall not determine whether a caregiver chooses to participate in the program, whether a caregiver will bring a particular person supported into his or her home, or how the day-to-day activities of the home and provision of services and supports will occur. Visits, both announced and unannounced, and phone calls to the home must occur on a regular basis in order for the provider agency to ensure compliance with program requirements and the general health and safety of the person supported, but should not be so prescriptive as to instruct the provider about particular tasks to perform or ways to fulfill or not fulfill duties. Family Model Support caregivers are responsible for abiding by the quality assurance standards, outlined in the DIDD Provider Manual, which are monitored and enforced by DIDD. A Family Model Residential Support home shall have no more than 3 residents who receive services and supports regardless of HCBS program or funding source.

The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports for up to 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work, based on the person’s support needs. Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk. Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to

ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such.

Family Model Residential Support shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

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

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

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

Effective March 13, 2020, the maximum limit for out-of-state services of 14 days per person supported per calendar year shall be extended as necessary during emergency situations impacting a significant portion of the population such as natural disasters or public health emergencies which would require broader use of out-of-state services to ensure continuity and quality of services to persons supported.

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

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

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

The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Family Model Residential Support service that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of "homebound" and as a result, is unable (not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time. 'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period. Effective March 13, 2020, during the COVID-19 emergency, due to the chronic nature of the threat of exposure to COVID-19, the homebound definition shall be met on any day when a person does not participate in employment or community activities due to stay-at-home orders and/or social distancing recommendations to prevent risk of exposure and spread of COVID-19. This temporary flexibility will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:

1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.
2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.
3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.
4. Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being. Effective March 13, 2020, during the COVID-19 emergency, this provision shall apply to any person previously receiving services to participate in integrated community employment or community activities (including Employment Supports--Individual or Small Group, Community Participation Supports, and Intermittent Employment and Community Integration Wrap-Around Supports) or previously receiving Facility-Based Day Supports who is unable to continue participation in such activity due to stay-at-home orders and/or social distancing recommendations to prevent risk of exposure and spread of COVID-19. This temporary flexibility will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the individual to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD (e.g., end of life). All individual goals and objectives, and specific needed supports, related to authorization of the RSNA- HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person-centered ISP.

The RSNA-HB can only be authorized and paid for services provided on the same day that Family Model Residential Support service is also authorized and provided.

Service Specification

Service Title: Medical Residential Services - Statewide (TN.0128) and CAC (TN.0357) Waivers only

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

Service Definition (Scope):

Medical Residential Services shall mean a type of residential service selected by the person supported, encompassing the provision of direct skilled nursing services and habilitative services and supports that enable a person supported to acquire, retain, or improve skills necessary to reside in a community-based setting, and which supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP. All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual..

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

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

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

The Medical Residential Services provider shall be responsible for the cost of all Day Services other than Supported Employment - Individual Employment Support (including Community Participation Supports, Facility-Based Day Support Services, Supported Employment- Small Group, and Intermittent Employment and Community Participation Wraparound supports) needed by the person supported and any skilled nursing services needed while receiving Day Services. In order to promote and incentivize participation in individualized integrated employment, a person receiving Medical Residential Services may also receive the Supported Employment-Individual Employment Support, and the provider shall not be responsible for the cost of this service.

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

Medical Residential Services may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Medical Residential provider shall oversee the health care needs of the person supported.

A Medical Residential Services home shall have no more than 4 residents with the exception of those homes which were licensed as a Residential Habilitation Facility prior to July 1, 2000. Individuals receiving Medical Residential services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

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

Since the Medical Residential Services provider is responsible for providing direct support and other services up to 24 hours per day 7 days per week when the person supported is not at school or participating in individualized integrated employment, based on a person's support needs, a person supported who is receiving Medical Residential Services shall not be eligible to receive Personal Assistance, Community Participation Supports, Facility-Based Day Support Services, Supported Employment- Small Group, Intermittent Employment and Community Participation Wraparound supports, or Respite. Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk. Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.

Medical Residential Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such.

Reimbursement for Medical Residential Services shall not be made for room and board or for the cost of maintenance of the dwelling if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the person supported, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the person supported and who provides services to the person supported in the place of residence of the person supported. If a person supported owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported, other residents in the home, and (as applicable) live-in or other caregivers.

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

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

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

Effective March 13, 2020, the maximum limit for out-of-state services of 14 days per person supported per calendar year shall be extended as necessary during emergency situations impacting a significant portion of the

population such as natural disasters or public health emergencies which would require broader use of out-of-state services to ensure continuity and quality of services to persons supported.

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

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

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

Service Specification

Service Title: **Non-Residential Homebound Support Services**

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

Service Definition (Scope):

Non-Residential Homebound Support Services shall mean a type of service offering individualized services and supports that enable the person to avoid institutionalization and live in the community in a non-residential setting of their choice, typically the family home or the individual's own home. Non-Residential Homebound Support Services shall be delivered in a manner that aligns with the individual's specific assessed need as set forth in the person- centered ISP.

Non-Residential Homebound Support Services is a per diem service that is provided in the individual's residence when the individual is determined to be homebound on a particular day and unable to leave their home. 'Homebound' is defined as being unable to leave your home for at least 2 hours per day for a sustained period of time which is at least 5 days in a 14-day billing period. (The 2 hours may or may not be consecutive). The Non- Residential Homebound Support Services per diem may be authorized to support waiver participants when they meet the definition of 'homebound' and therefore are unable to participate in an employment or day service and need to remain at their residence for the full twenty-four hours of the day, except leaving the home for medical treatment or medical appointments. Effective March 13, 2020, during the COVID-19 emergency, due to the chronic nature of the threat of exposure to COVID-19, the homebound definition shall be met on any day when a person does not participate in employment or community activities due to stay-at-home orders and/or social distancing recommendations to prevent risk of exposure and spread of COVID-19. This temporary flexibility will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

The intent of the Non-Residential Homebound Support Service is that it be authorized on an as needed basis, not on a continuous basis unless justified (e.g. end-of-life circumstances or serious prolonged illness). The service is authorized on a per diem basis and can be authorized in addition to personal assistance quarterly units; however, the two services shall not be provided or reimbursed at the same time. Non-Residential Homebound Support Services shall not be provided or paid on any day when any other employment or day service is provided. Non-Residential Homebound Support Services shall not be provided at the same time as any other Waiver services, provided that therapy services (Physical Therapy, Occupational Therapy, Speech, Language and Hearing) and Behavior Services may be provided while a person is receiving Non-Residential Homebound Support Services when appropriate based on the individualized needs and goals of the person supported. Nursing Services may be provided at the time as the Non-Residential Homebound Support Service only on an intermittent basis and limited to no more than one hour to perform specific skilled nursing tasks that cannot be performed by or delegated to the staff providing the Non- Residential Homebound Support Service. When Nursing Services are provided for a longer period, the nurse shall also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the person supported during the period that Nursing Services are authorized and provided. The Non-Residential Homebound Support Service per diem is to be used only on days, beyond the first four (4) days in any 14-day billing period that the individual is considered 'homebound', when the person cannot go out of their house for the entire twenty-four hour period due to their circumstances, except leaving the home for medical treatment or medical appointments.

For an individual to be eligible for the Non-Residential Homebound Support Service, the person is unable to leave his/her home for at least 2 hours per day (hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period, due to one or more of the following criteria:

1. Engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.
2. Engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to needs related to a sustained behavioral crisis, involving behaviors

not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.

3. Engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to needs related to recovery after a period of hospitalization (e.g. discharge after surgery), recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.

4. Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the person's health and physical well-being. Effective March 13, 2020, during the COVID-19 emergency, this provision shall apply to any person previously receiving services to participate in integrated community employment or community activities (including Employment Supports--Individual or Small Group, Community Participation Supports, and Intermittent Employment and Community Integration Wrap-Around Supports) or previously receiving Facility-Based Day Supports who is unable to continue participation in such activity due to stay-at-home orders and/or social distancing recommendations to prevent risk of exposure and spread of COVID-19. This temporary flexibility will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

Non-Residential Homebound Support Service is only used in the above exceptional circumstances and is to be used only as needed and only on days when the above criteria are applicable. Authorizations for Non-Residential Homebound Support Service are to be reviewed and reauthorized, as appropriate, every 90 days.

All individual goals and objectives, and specific needed supports, related to authorization of the Non-Residential Homebound Support Service shall be established through the person-centered planning process and documented in the person-centered ISP. Supports may include of direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, meal preparation excluding cost of food, toileting and incontinence care, assistance with transfer and mobility), and household chores essential to the health and safety of the person supported (e.g., washing dishes; personal laundry; general housecleaning in areas of the residence used by the person supported). Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being.

The Non-Residential Homebound Support Service may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Non-Residential Homebound Support Service per diem requires a minimum of six (6) hours of service to be delivered on the day for which it is billed. The six (6) hours of service may be provided during the day or night, as specified in the person-centered ISP.

Service Specification

Service Title: **Orientation and Mobility Services for Impaired Vision**

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

Service Definition (Scope):

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

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

Orientation and Mobility Services for Impaired Vision shall be provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). Orientation and Mobility Services for Impaired Vision shall be provided face to face with the person supported except for training of caregivers responsible for assisting in the mobility of the person supported and except for that portion of the assessment involving development of the plan of care. Only during the COVID-19 emergency, Orientation and Mobility Services for Impaired Vision may be provided via telehealth. Generally, this means that the person and the provider are connected via an interactive audio and video telecommunications system. Any components of the service requiring direct evaluation and interactive, hands-on care to be effective and therapeutic are excluded.

Therapeutic goals and objectives shall be required for persons supported receiving Orientation and Mobility Services for Impaired Vision. Continuing approval of Orientation and Mobility Services for Impaired Vision shall require documentation of reassessment of the condition and continuing progress of the person supported toward meeting the goals and objectives.

Orientation and Mobility Services for Impaired Vision shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Behavior Services, Speech, Language, and Hearing Services, or except during the COVID-19 emergency, Nutrition Services, unless there is documentation in the record of medical justification of the person supported for the two services to be provided concurrently.

Orientation and Mobility Services for Impaired Vision shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

The unit of reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with plan development shall be per day. The unit of reimbursement for other Orientation and Mobility Services for Impaired Vision shall be per 15 minutes.

Reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with development of the plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Orientation and Mobility Services for Impaired Vision assessments shall not be billed on the same day with other Orientation and Mobility Services for Impaired Vision services. Orientation and Mobility Services for Impaired Vision services other than such assessments (e.g., person supported training; person supported-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of 52 hours of services per person supported per calendar year. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Orientation and Mobility Services for Impaired Vision unless provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

Service Specification

Service Title: **Personal Assistance**

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

Service Definition (Scope):

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

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

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

Personal Assistance may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

Personal Assistance is a service that is provided for the direct benefit of the person supported. It is not a service that provides direct assistance to other members of the household (e.g., preparation of meals for the family, family laundry) who are not persons supported through the waiver. Personal Assistance staff shall not provide any personal assistance services to family members of the person supported, unless such family members are also supported through the waiver residing in the same home (e.g., when 2 siblings in the home are both waiver participants).

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

Documentation of service delivery must be kept for each person supported and shall reflect the total number of shared units of service provided, and the tasks performed/assistance provided for that individual.

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

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

held in the home of the Personal Assistant. Services provided in the Personal Assistant's home must be specified and in accordance with the approved person-centered ISP.

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

Personal Assistant Services shall not be provided during the same time period that the person supported is receiving Day Services, Respite Services, services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Only during the COVID-19 emergency, DIDD may authorize the provision of Personal Assistance services in a hospital or other temporary health care facility created for purposes of responding to the COVID-19 emergency when permitted and when the frequency and intensity of hands-on or supervisory needs is such that the person's needs cannot otherwise be reasonably accommodated in that setting. Personal Assistance shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home) when the facility's licensure category requires the provision of personal assistance or personal care services.

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

Family members are required to implement services as specified in the person-centered ISP.

Reimbursement to family members shall be limited to forty hours per week per family member. This limitation of forty hours per week on payment to family members is waived *only* during the period of the emergency when approved by DIDD as determined to be needed to ensure access to needed care, and will resume as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

The unit of reimbursement for Personal Assistance services shall be 15 minutes.

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

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

a. Out-of-state services shall be subject to the same monthly limitation as Personal Assistance services provided in-state and in addition, are limited to a maximum of 14 days of service per person supported per waiver program year (calendar year), regardless of the number of hours of service provided each day. Effective March 13, 2020, the maximum limit for out-of-state services of 14 days per person supported per calendar year shall be extended as necessary during emergency situations impacting a significant portion of the population such as natural disasters or public health emergencies which would require broader use of out-of-state services to ensure continuity and quality of services to persons supported.

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

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

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

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

Service Specification

Service Title: **Supported Living - Statewide (TN.0128) and CAC (TN.0357) Waivers only**

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

Service Definition (Scope):

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

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

Supported Living may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The SL provider shall oversee the health care needs of the person.

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

A SL home shall have no more than 3 residents including the person supported. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must pass a home inspection approved by the State Medicaid Agency.

The Supported Living provider shall be responsible for providing an appropriate level of services and supports up to 24 hours per day during the hours the person is not receiving Day Services, is not otherwise engaged with natural supports, is not at school or work, based on the person's support needs. Persons should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk. Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule. Thus, a person supported who is receiving SL shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the SL provider).

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

In Supported Living companion model, family and friends of the companion staff may only reside in the home of the person supported when approved by the person or his/her conservator. Such approval shall be documented in the person-centered ISP. Individuals receiving Supported Living services may choose to receive

services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

Supported Living shall not be covered for persons supported under age 18 years.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such.

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

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

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

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

Effective March 13, 2020, the maximum limit for out-of-state services of 14 days per person supported per calendar year shall be extended as necessary during emergency situations impacting a significant portion of the population such as natural disasters or public health emergencies which would require broader use of out-of-state services to ensure continuity and quality of services to persons supported.

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

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

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

The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Supported Living service that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of 'homebound' and as a result, is unable (not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time.

'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period. Effective March 13, 2020, during the COVID-19 emergency, due to the chronic nature of the threat of exposure to COVID-19, the homebound definition shall be met on any day when a person does not participate in employment or community activities due to stay-at-home orders and/or social distancing recommendations to prevent risk of exposure and spread of COVID-19. This temporary flexibility will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the

COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:

1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.
2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.
3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.

Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the person's health and physical well-being. Effective March 13, 2020, during the COVID-19 emergency, this provision shall apply to any person previously receiving services to participate in integrated community employment or community activities (including Employment Supports-- Individual or Small Group, Community Participation Supports, and Intermittent Employment and Community Integration Wrap-Around Supports) or previously receiving Facility-Based Day Supports who is unable to continue participation in such activity due to stay-at-home orders and/or social distancing recommendations to prevent risk of exposure and spread of COVID-19. This temporary flexibility will be implemented as determined by TennCare, working in collaboration with DIDD, to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the person to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD(e.g., end of life).

4. All individual goals and objectives, and specific needed supports, related to authorization of the RSNA-HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person-centered ISP. The RSNA- HB can only be authorized and paid for services provided on the same day that SL service is also authorized and provided.

ⁱ Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment

rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.