






# **Overview of Proposed Amendments and Changes to Integrate and Transform Long-Term Services and Supports (LTSS) for People with Intellectual and Developmental Disabilities (I/DD)**

## Key




**We are listening...**

Throughout this document, we use this icon to point out some of the ways in which input is specifically reflected in the proposed plan.



**We want you to know...**

Throughout this document, we use this icon to highlight some of the most important messages or ideas.



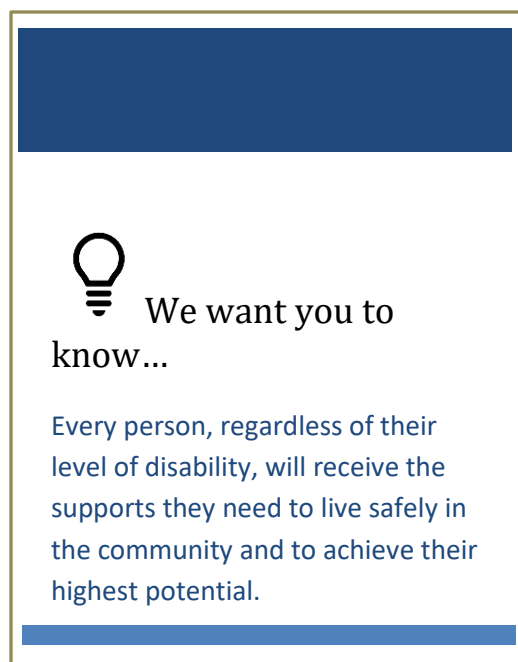
## Overview of Proposed Amendments and Changes to Integrate and Transform LTSS for Individuals with I/DD


### Introduction

In Tennessee and across the nation, people living with intellectual and developmental disabilities (I/DD) are experiencing life in a very different way than they were even a decade or so ago. Tennessee has made tremendous progress and is proud to have left large congregate institutions behind, turning staunchly toward an approach that is person-centered and understands that people with disabilities want to live their lives on their own terms, in their own homes and communities. They want (and indeed *are entitled* under the law to) the same rights and freedoms, the same opportunities to work and participate fully in all aspects of community life.

And yet we must continually ask ourselves if these values are evident in our Medicaid policies, programs, and payment systems. Do our outcomes support that people with I/DD are indeed supported to work in integrated settings earning a competitive wage, achieve economic and personal independence, have friends and relationships with people who are not paid to be with them, fully engage and *lead* as citizens of their communities? Are we supporting people to live as we say we believe they can?

The nearly 20 years of litigation due to conditions of poor treatment in our institutions produced needed expansion and improvement in Tennessee’s home and community-based services. However, it also inadvertently produced a system and requirements often colored through the lens of an institutional mindset that tend toward paternalism and low expectations, a system that can be administratively burdensome and expensive, and one that, in many cases, has not been fully modernized to meet the expectations and support the full potential of people living with disabilities today.



 We want you to know...

Every person, regardless of their level of disability, will receive the supports they need to live safely in the community and to achieve their highest potential.

**These proposed amendments mark the next phase of Tennessee’s decades long system transformation (and ultimately, *culture* transformation) in supporting people with I/DD in Tennessee and across the country.**

**It continues our shared efforts to create a “new and better way,” and at the same time affirms our unwavering commitment to continuity and careful transition between two worlds – the “old” and “new” – where no one, regardless of the level of their disability or their need for support, is left out or left behind.**



We want you to know...

We are not “starting from scratch.” In developing this proposal, we started with feedback received from stakeholders over a period of many years. And we continue to gather more.

It is a transformation that had its beginnings in late 2013 as TennCare and DIDD began gathering input that ultimately informed the design and launch of Employment and Community First CHOICES, a managed LTSS (MLTSS) program specifically designed to align incentives toward supporting competitive, integrated employment and independent community living as the first and preferred goal for people with I/DD. It was then that we began to ask those to whom it most mattered how things could and *should* be different—both as we sought to improve our current programs and to create a new one.

Building on that input, in mid-2016, TennCare and DIDD jointly launched a System Transformation Initiative across Medicaid programs and authorities that serve more than 40,000 people in institutional and home and community based service settings, with the goal of transforming the entire LTSS system to one that is person-centered and that aligns policies, practices, and payments with system values and outcomes.

## System and Culture Transformation Initiative

### Key Elements of a Person-Centered Delivery System

-  Develop quality person-centered support plans that reflect a person's goals and choices
-  Make sure services are provided in the least restrictive, most integrated way
-  Provide services and supports that maximize independence and interdependence
-  Promote employment as possible and expected for working-aged adults and support inclusion for all people

-  Develop best practices and a learning culture
-  Address program barriers such as the workforce crisis and inspire trust through responding to needs
-  Meaningfully engage and work together with stakeholders
-  Promote autonomy and important values such as person-centeredness, self-determination, and dignity of choice

TennCare and DIDD, in collaboration with a statewide System Transformation Leadership Group (STLG) comprised of self-advocates, family members, advocates, providers, health plan partners, and state leadership, identified key drivers of transformation at the person or individual level, the provider or service delivery level, and the program or system level, recognizing that advancements—especially at the system level—will help to achieve a broader culture transformation when people with disabilities are better supported to enjoy the rights, valued roles, and quality of life that other citizens are afforded. These drivers guided efforts by each agency to advance this work.

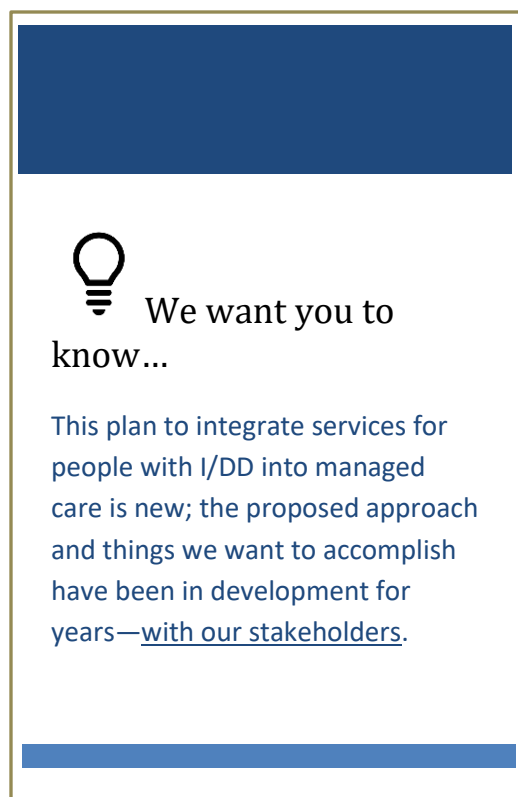
As a new Administration launched in 2019, TennCare and DIDD began meeting to emphasize this vision, reflective of input gathered over years, in each agency’s multi-year strategic planning process. At the time, there was no talk of integration; the focus remained squarely on how best to advance a person-centered delivery system. The result of these meetings was an agreement on a set of shared strategic objectives to further the transformation effort:


- Embed person-centered thinking, planning and practices and align key requirements and process across Medicaid programs and authorities in order to **create a single, seamless person-centered system of service delivery for people with I/DD**, including: critical incident management, quality assurance and improvement, direct support workforce training and qualifications, provider qualifications and enrollment/credentialing processes, value-based reimbursement approaches aligned with system values and outcomes.
- **Increase the capacity, competency and consistency of the direct support workforce.**
- **Support the independence, integration, and competitive, integrated employment of individuals with I/DD** through the use of effective person-centered planning, enabling technology, and the development of natural supports as evidenced by an increase in the number of working age adults participating in competitive, integrated employment, and the transition of persons supported to less intensive support arrangements based on individualized needs and preferences.
- Partner with TennCare-contracted MCOs to build the statewide capacity and continuum of the behavioral health system to **meet the needs of individuals with I/DD who have co-occurring mental health conditions or behavior support needs in a person-centered way** (moving toward independence and integration to the maximum extent appropriate).
- **Integrate the budgeting process** for programs and services for people with I/DD in order to best meet the needs of all Tennesseans with I/DD and their families.
- **Eliminate the waiting list** of persons with I/DD who are actively seeking to enroll in Medicaid services.

As the first FY 20-21 budget passed in mid-March 2020, it appeared we were well on the way, with funding recommended by the Governor and approved by the General Assembly to advance many of these objectives.

While the budgetary challenges brought on by the COVID-19 public health emergency brought unanticipated challenges (including the loss of previously approved funding to serve 2,000 people from the waiting list and to launch new value-based workforce incentives), it also brought opportunity—to take action that will have significantly greater impact in achieving the vision of true transformation.

**With a Concept Paper released in July, TennCare and DIDD proposed to integrate all Medicaid programs and services for individuals with I/DD—including Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID), the Section 1915(c) home- and community-based services (HCBS) waivers, and Employment and Community First CHOICES<sup>1</sup> into the managed care program, under the direct operational leadership, management, and oversight of DIDD.**



 We want you to know...

This plan to integrate services for people with I/DD into managed care is new; the proposed approach and things we want to accomplish have been in development for years—[with our stakeholders](#).

The *Concept Paper* reflected a vision that was both fresh (barely a month old in terms of the proposed integration into managed care) and also seasoned—developed over many years of listening to and partnering with those served in our programs, their families and advocates, and the providers who actually deliver these important services and supports.

Following the announcement and release of the *Concept Paper*, the two agencies partnered to begin engaging with stakeholders to gather additional input that would help to inform a more detailed plan. We immediately scheduled discussions with the provider association--Tennessee Community Organizations (TNCO), the Council on Developmental Disabilities, The Arc of Tennessee, Disability Rights Tennessee, and the Tennessee Disability Coalition. In light of potential risks of in-person meetings, we scheduled webinars open to the broad stakeholder community, turning the **Concept Paper** into a **Concept presentation**, and responding to questions.

We were then asked by stakeholders to develop a more “person and family friendly” version of the materials and to schedule a time just for these groups, where they could more freely ask *their* questions and share *their* thoughts and ideas. We did so and are grateful to the Tennessee Council on Developmental Disabilities for leading the development of those materials, which were presented on multiple occasions. We were also asked to extend the time period for input following those discussions to allow more time for their thoughtful input, which we did—until nearly the end of August. By that time, we had received more than 100 pages of detailed comments online, as well as lengthy letters from many advocacy groups and TNCO.

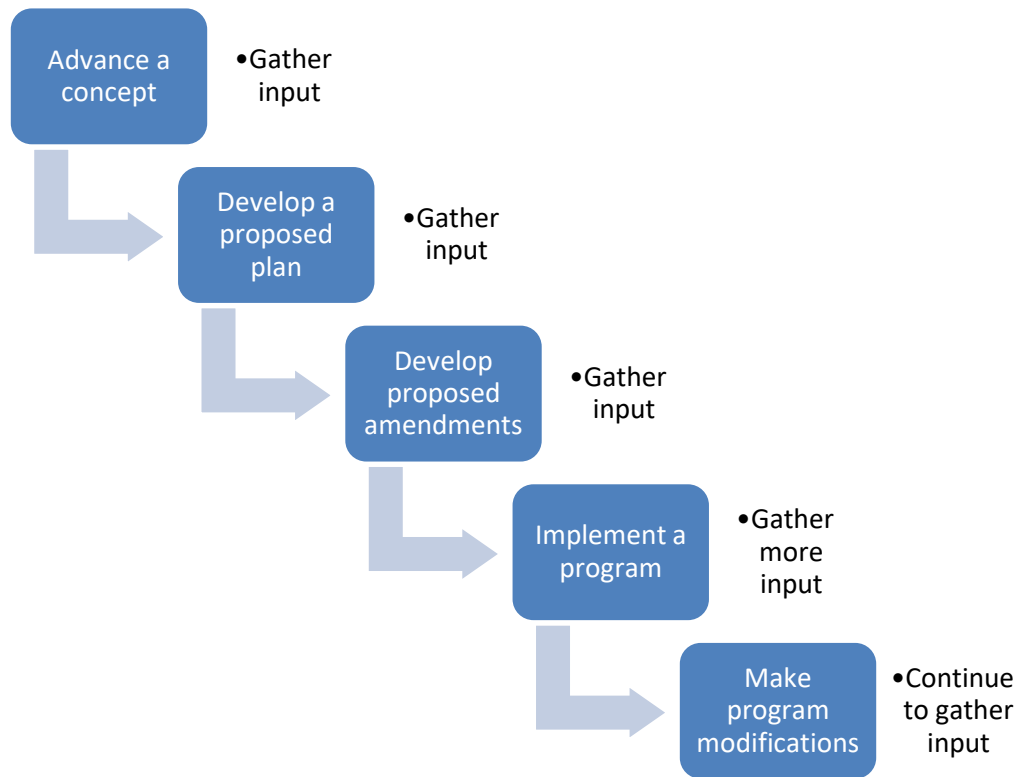
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<sup>1</sup> Employment and Community First CHOICES is already part of the managed care program, but not under the direct operational leadership, management and oversight of DIDD.

At the conclusion of the period, we spent a few weeks analyzing, summarizing, and thoughtfully considering all of the input to inform a more detailed plan: this **Overview of Proposed Amendments and Changes to Integrate and Transform Long-Term Services and Supports (LTSS) for People with Intellectual and Developmental Disabilities (I/DD)**.

This is not a “typical” step in the amendment process. This approach-- to advance a concept, gather input, develop a plan, gather input, develop proposed amendments, gather input, implement a program, gather more input, make program modifications,

continue to gather input...—is one that has been used for other LTSS initiatives, making sure that those who have the greatest stake in a system are afforded ample opportunity to help shape and reshape the public policy that guides that system forward.



### **Context of This Document**

Typically, a request to modify the TennCare II demonstration would be submitted as an 1115 waiver amendment. However, the current TennCare II demonstration waiver expires on June 30, 2021, and must be renewed. The Centers for Medicare and Medicaid Services has thus advised that rather than submitting this request as an amendment, it should be submitted as part of the renewal of the TennCare II demonstration waiver. The demonstration renewal application must be submitted to CMS by December 31, 2020. In an effort to ensure even more opportunity for public comment, TennCare and DIDD are posting these *“Proposed Amendments to Integrate and Transform Long-Term Services and Supports for People with Intellectual and Developmental Disabilities”* now.



### We are listening...

This document is primarily to help stakeholders understand the “bigger picture” in order to inform additional input regarding proposed changes. We will consider all of the input in developing actual draft documents ... which will be posted for additional public comment prior to submission to CMS.



In further interest of transparency, we note not only proposed changes to the TennCare II Demonstration that will be sought as part of the renewal of the 1115 demonstration waiver but, also highlight expected changes that will be requested in the 1915(c) HCBS waivers and the Medicaid State Plan via amendments to each respective document. A summary of all of these changes is included in Appendix A.

By including this information, we seek to provide a more complete picture of the proposed changes to the I/DD service delivery system. Even after we review public comments on the proposed changes across Medicaid authorities received in response to this document, additional opportunities for public review and comment will occur as a more formal part of the submission of each request—Amendments to the Section 1915(c) Waivers, Renewal of the TennCare II Demonstration, and the Amendment to the Medicaid State Plan.

Finally, in addition to previewing proposed changes to the Medicaid authorities under which TennCare’s LTSS for individuals with I/DD operate, we also provide explanation of how the system is structured today, how it can be different, and we offer detail regarding how changes will be operationalized. While some are beyond the scope of federal authority (and thus will not actually be part of proposed amendments), we share this additional detail in order to further explain how the system will actually work to better support people with I/DD in living the lives they choose.

## Overview of Proposal

### Key Objectives

At its core, these amendments are about continued system transformation—creating a single, seamless person-centered system of service delivery for people with I/DD that empowers their full citizenship, ultimately achieving culture transformation. System transformation is not a point-in-time event, but rather a process that will occur over time. These amendments provide authority to make changes that we expect will substantially advance our progress toward the ultimate goal over time.



### We want you to know...

Implementation will not happen all at once—on July 1, 2021. Changes will occur over time, carefully ensuring continuity and stability.







To be clear, it is a goal **for all**, not for some. In that regard, we will not leave behind those currently enrolled in these programs who have more significant disabilities or who face greater challenge in finding their own unique place in community. The vision of possibility—in employment, in community living—is for one and for all. This includes those waiting for services. Thus, these amendments are also about ensuring equal access to services through the responsible and effective management of limited resources. It is not about taking from some and giving to others, but rather making sure the services and supports provided are uniquely and individually matched to each person’s needs, always with eye toward empowering each person to the extent possible to rely less on paid services when appropriate, and to more fully embrace a life of independence and interdependence, a life of self-determination, in community.

### New Contract Structure

Under the proposed amendments to integrate and transform programs and services for people with I/DD, all LTSS for individuals with I/DD will be part of the managed care program. This means that for each person receiving Medicaid LTSS (including 1915(c) HCBS waiver and Intermediate Care Facility for Individuals with Intellectual Disabilities or ICF/IID services), their currently assigned Managed Care Organization (MCO)—the entity already charged with administering their physical and behavioral health benefits—will also have a role to play in their LTSS as well. People with I/DD are not being “moved into managed care.” They are already in managed care. Rather, their LTSS benefits will now be brought into managed care as well. These LTSS will be administered through the managed care program under the direct operational leadership, management, and oversight of DIDD.

Managed care programs have increased exponentially across the country. More and more, these programs are beginning to “carve in” benefits, including LTSS, for people with I/DD. Just the term “managed care” can spark fear among some groups...fear that services will be reduced or denied in the interest of saving money; that managed care organizations will be incentivized to withhold services in order to drive organizational profit; that people with the most significant needs will not have the supports they need to live in the community and will end up institutionalized; that longstanding community providers will be left out of the network, not paid at a level that allows them to sustain service delivery, or caught up in an endless mire of administrative complexities they cannot negotiate; or that the values and principles self-advocates, families, advocacy organizations, and state I/DD agencies have long fought to establish will be lost or at least diminished in favor of efficiency.



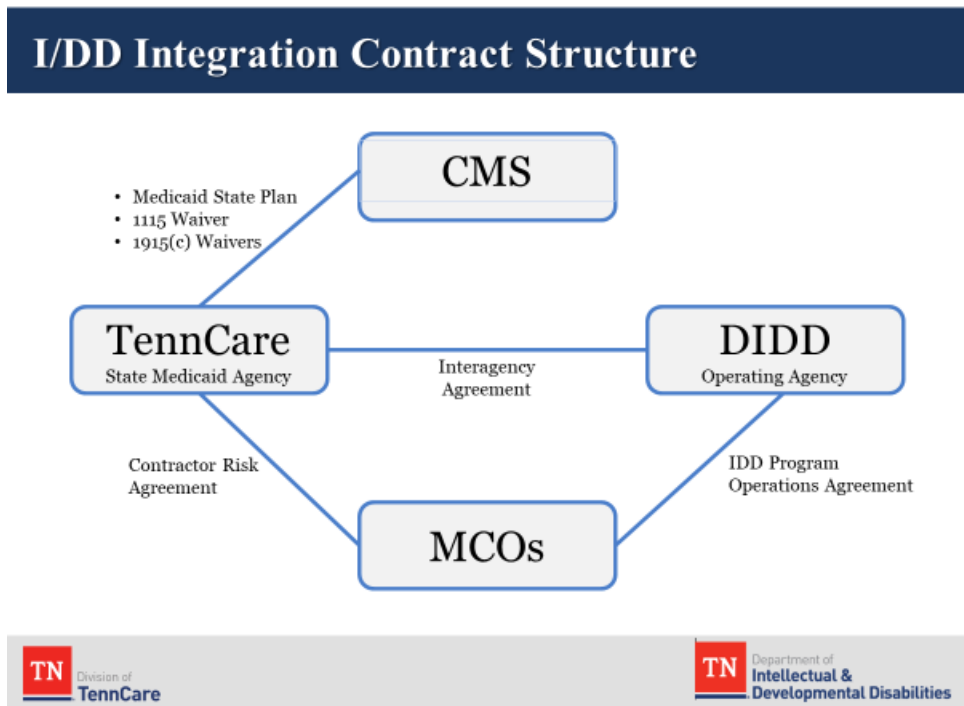
 We want you to know...

People with I/DD are not being “moved into managed care.” They are already in managed care. Rather, their LTSS benefits will be brought into managed care as well. These LTSS will be administered through the managed care program under the direct operational leadership, management, and oversight of DIDD.

TennCare and DIDD seek to demonstrate a managed care approach that works **for** people with disabilities by:

- Preserving, protecting and indeed **strengthening** core system values;
- Aligning incentives in ways that will support the achievement of individual and system goals;
- Bringing to bear all of the tools and capacities that experienced health insurance companies have to coordinate and improve health care and health outcomes especially for those with the most complex and chronic needs and disabilities, based on each person’s individualized support needs and plan;
- Reducing administrative burden for providers and helping them develop their capacity to deliver high quality support and produce high quality outcomes and paying for them more for doing so; and
- Providing a direct leadership and oversight role for the state I/DD agency that will help to ensure that the person is always at the center of how supports are delivered.

As the federally designated State Medicaid Agency, TennCare will contract with DIDD to serve as the operational lead agency for all I/DD programs and services. This includes the 1915(c) Waivers, Employment and Community First CHOICES, and ICF/IID services. TennCare will continue to maintain a Contractor Risk Agreement with MCOs (encompassing the broader TennCare program requirements, including physical and behavioral benefits), with DIDD entering into a separate I/DD Program Operations Agreement which will clearly define DIDD’s authority in leading the day-to-day management and oversight of the MCO contracts for I/DD benefits.



At the onset, payments to MCOs for LTSS provided to the I/DD population will not be fully risk-based but will include incentives to align with the achievement of individual and program goals (as further described in the value-based reimbursement section below).

### Program and Benefit Structure

**The vision is a single, seamless person-centered system of service delivery for people with I/DD.** However, we recognize that these programs today are quite different.

The integration of Medicaid LTSS programs and services for people with I/DD calls for a careful balance—seeking to advance toward the creation of a single, aligned, person-centered program of support for people with I/DD and their families, while also ensuring stability and continuity of important services and longstanding relationships with providers and direct support staff.

Accordingly, TennCare and DIDD propose to maintain the separate programs for the time being. The system will continue to include Employment and Community First CHOICES, three Section 1915(c) Waivers (the Statewide Waiver, Comprehensive Aggregate Cap Waiver, and Self-Determination Waiver), all operated concurrently under 1915(c) and 1115 Waiver authority to provide additional flexibility; and ICF/IID services.

TennCare and DIDD also propose largely maintaining the current benefit structure in each of the applicable programs and beginning to evolve these benefits in a manner that aligns with the intended goals of the new integrated and aligned system—leveraging effective person-centered planning, Employment Informed Choice,<sup>2</sup> enabling technology, telehealth, value-based payment, and other approaches to advance the achievement of person-centered goals, including employment, independence, and integrated community living.

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<sup>2</sup> As currently applied in Employment and Community First CHOICES, Employment Informed Choice is the process the MCOs must complete for working age members (ages 16 to 62) who are eligible for, and want to receive, Community Integration Support Services and/or Independent Living Skills Training services when the member is not engaged in or pursuing integrated employment. The Employment Informed Choice process includes, but is not limited to, an orientation to employment, self-employment, employment supports and work incentives provided by the member’s support coordinator; the authorization and completion of Exploration services in order to experience various employment settings that are aligned with the member’s interests, aptitudes, experiences and/or skills and ensure an informed choice regarding employment; and signed acknowledgment from the member/representative if the member elects not to pursue employment. Roughly 70% of people who complete the Employment Informed Choice process elect to pursue employment.



**We are listening...**

- Payments to MCOs for LTSS provided to people with I/DD will **not** be risk-based for now.
- All of the current programs will continue on July 1, 2021.
- No benefits are being eliminated.

Assessing potential for the use of enabling technology as an integral part of the person centered planning process and ensuring access to enabling technology as a distinct benefit will be important across all of these programs, as will ensuring that reimbursement for services such as residential, personal assistance, individual employment supports, etc. includes technology-based support rates, as appropriate.

#### Consumer Direction


Based on input, consumer (or self) direction will be available in each of the 1915(c) waivers for services like Personal Assistance, Respite, and Community Transportation.

#### Therapy, Behavior and Nutrition Services

As it relates to occupational therapy (OT), physical therapy (PT), speech, behavior services and nutrition services, we intend to move toward a consultative model similar to that used in Employment and Community First CHOICES, leveraging licensed professionals to teach, train and support paid and unpaid caregivers, embedding appropriate treatment within the day-to-day delivery of supports in order to maximize both the efficacy and efficiency of service delivery. This could be accomplished in a number of different ways—by redefining the scope of these services as part of 1915(c) amendments and/or by leveraging telehealth options and/or value-based payment to drive toward preferred outcomes. We seek input regarding these and other potential strategies. In any option, a plan for fading direct services when appropriate is an essential component.

#### Nursing Services

As the population ages and people with disabilities are living longer, the need for nursing care—in hospitals, nursing homes, and in people’s homes and other community-based settings—is outpacing the supply of nursing services. Like many states, Tennessee faces a shortfall of nurses. However, in light of the gap between supply and demand, Tennessee has lagged behind the vast majority of other states in utilizing various flexibilities to drive a more efficient way to meet skilled needs in the community.



We want you to know...

Across the programs, you will see a focus on identifying opportunities where technology can empower each person to have greater control and independence in their own life—whether or not it impacts their need for paid support. This does not mean people “have to” use technology; rather they have an **opportunity** to understand how it can improve their lives.



## We want you to know...

Therapies, nutrition services, and nursing services will continue to be covered benefits. However, we will begin to evolve how those services are provided in order to increase both the efficacy and efficiency of service delivery, while ensuring that each person's needs are safely met.

Highly skilled health care professionals are often required to perform routine health maintenance tasks that are frequently performed by unskilled family caregivers—at a high cost to the Medicaid program and to the system as a whole in terms of utilizing limited nursing resources.

As an example, in the HCBS waivers, a person may receive significant hours of skilled nursing services or be admitted to Medical Residential Services when the only needed nursing task is a periodic finger stick to check blood sugar or the administration of nebulizer treatments or oxygen—tasks that are easily taught and performed by unskilled workers (and at a significantly lower cost), freeing up limited nursing capacity to meet more complex skilled needs.

Requiring that such tasks are performed only by a licensed nurse drives up the cost of providing care in the community, forces more people into expensive institutional placements,

and limits the ability to cost-effectively serve more people in HCBS settings. As Tennessee continues to move toward serving more people in community settings, we must restructure the way nursing care is delivered and utilize registered nurses more in their teaching and consulting roles.

It is critical that we begin to move forward with strategies to teach, train, and support paid (or when available and willing, unpaid) caregivers to perform those more routine (i.e., non-complex) health care tasks, potentially coupled with remote support (or telehealth consultation on an as needed basis). This would increase access to community living, remove potential barriers to transition from institutions, and leverage limited skilled nursing resources to practice at the top of the license, performing the most complex skilled tasks directly, while ensuring that individuals with skilled nursing needs can continue to have their needs safely met in the community. Research has borne out that quality of care is not compromised by allowing these flexibilities, and in some cases, is improved. This could also be accomplished in a number of different ways—by changes to the scope of the benefit and/or through a modified payment structure, with significantly higher payment for services that help to expand capacity to deliver needed care. We seek input regarding these and other potential strategies.

## Residential and Day Services

In order to better align reimbursement with individualized needs, we plan to combine residential and most day services into a single benefit entitled – Community-Based Living Supports (CBLs). This will help to ensure that a person’s day is not artificially delineated between the six hours of support payment derived from the receipt of “Day” services—typically outside the home, and the remaining hours derived from the residential payment—typically inside the home, an approach that harkens back to the “programs” of years ago rather than the individualized supports people want and expect to receive today. The provider will be responsible for delivering the supports each person needs to achieve their identified outcomes, participate in the activities of his/her choosing, at the time of his/her choosing, and in the setting of his/her choosing, so long as compliance with the HCBS Settings Rule is maintained. To be clear, all day services currently available to persons enrolled in these waivers will continue

to be available, and providers will be paid to deliver both types of assistance. Payments for these services will be combined with payments for traditional “residential” services into a more modernized and flexible individualized benefit driven by the needs and preferences of the person.

In order to support persons in pursuing and achieving competitive integrated employment, employment services, including Job Coach, will continue to be reimbursed separately, and will include technology-based support options.

## ICF/IID Services

As noted in the introduction, in the last decade, Tennessee has closed each of its three remaining congregate institutions for people with intellectual disabilities. One of the individuals transitioning to the community and electing to participate in Tennessee’s successful Money Follows the Person Rebalancing Demonstration was the longest institutionalized person under the program—finally attaining community living following a period of living in an institution for more than sixty (60) years.

While abiding by freedom of choice as currently described in the federal regulation resulted in a number of smaller 4-bed ICF/IID “homes” being established across the state to serve transitioning residents (public as well as privately operated facilities), the overall growth in ICF/IID services in Tennessee has remained low—due in part to a statutory cap on new Certificates of Need for private ICF/IID facilities. Currently there are 804 private beds (including small 4-bed as well as larger facilities established prior to the 4-bed limit effective June 2000), five state-owned but privately operated 4-bed ICF/IID “homes” (20 beds), 37 publicly owned and operated 4-bed ICF/IID “homes” located across the state (148 total beds), and 12 Day



We are listening...


All of the current residential and day service options will continue to be available. We are combining the services and the payment for these services to provide greater flexibility with regard to how people spend their day.


One public ICF/IID beds at the Harold Jordan Center. In total, these nearly 1,000 beds represent roughly 10 percent of persons with I/DD receiving LTSS, and more than 20% of total LTSS expenditures for people with I/DD. While DIDD maintains well-defined admission criteria and processes for the public facilities, the threshold for ICF/IID medical (level of care) eligibility is very low—an intellectual disability combined with a single activities of daily living (ADL) deficiency. The lack of other effective means of oversight regarding private ICF/IID admission results in people being placed in ICFs/IID that could be served in more integrated community settings, and at a lower cost.

TennCare and DIDD explored the possibility of changing the ICF/IID level of care criteria, but based on input, did not want to consider changes that could also negatively impact eligibility for the 1915(c) waivers (which are tied under the federal regulation to the comparable level of institutional care).<sup>3</sup>

In order to ensure continuity for persons currently receiving ICF/IID services while directing new enrollment (to the maximum extent possible and appropriate) to more integrated and cost-effective HCBS settings, we propose the following:

- We will continue to cover ICF/IID services but move the benefit from the Medicaid State Plan to the 1115 demonstration. This will assure continuity of care for individuals currently receiving these services.
- Beginning on July 1, 2021, in addition to meeting ICF/IID level of care criteria, new admissions to an ICF/IID will be limited to persons with such significant co-occurring behavioral challenges or complex medical needs that the person cannot be immediately served in a more integrated setting, and only for the limited period of time that is necessary to complete a comprehensive assessment of their community living needs, develop a comprehensive transition plan, identify a community provider and seamlessly transition to a more integrated community setting.



 We want you to know...

ICF/IID services will continue to be covered under the 1115 waiver, offering greater flexibility to align the provision of these services under the Medicaid program with the requirements of the ADA. By changing how the benefit is utilized, we can leverage these services for shorter term placements that will provide for transition to more integrated settings as appropriate.

<sup>3</sup> TennCare will request waiver and expenditure authority to expand the ECF Working Disabled demonstration group to include individuals enrolled in a Section 1915(c) waiver as of July 1, 2021, and to expand Medicaid eligibility categories covered under the 1915(c) waivers to include the ECF Working Disabled demonstration group. This will allow individuals enrolled in a 1915(c) waiver who are working to have earned income up to 250% of the FPL excluded when considering their continued eligibility for Medicaid and for HCBS.

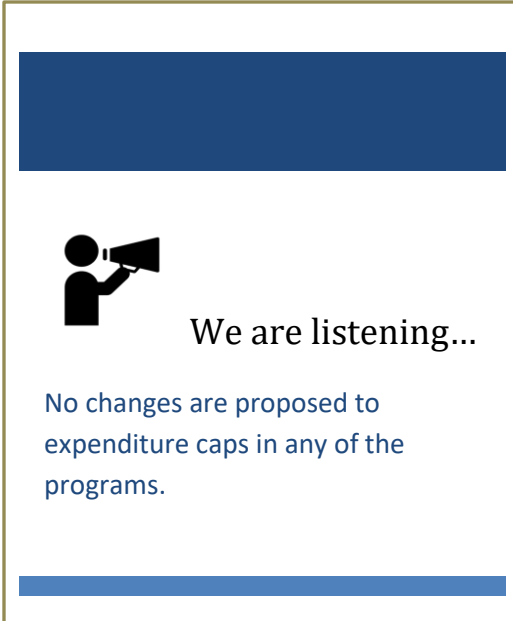
These determinations will be made by an Interagency Review Committee led by DIDD and will include TennCare and MCO clinical and program leadership. Further, before any such admission could be approved, the person would participate in an Community Informed Choice Process conducted by an entity other than an ICF/IID provider to ensure that s/he fully understands the full array of community-based options available to meet his/her needs, and having been fully informed, affirmatively chooses the institutional placement. This will better align the provision of these services with federal law that did not exist when the benefit was first established—namely, the Americans with Disabilities Act.

- Beginning no earlier than July 1, 2022, TennCare and DIDD, working with MCOs, will commence an individualized review process in order to identify individuals receiving ICF/IID services as of July 1, 2021, who can be supported in more integrated community settings and following a Community Informed Choice process, elect to do so, and work with each such person identified to complete an individualized comprehensive assessment of their community living needs, develop a comprehensive transition plan, identify a community provider and seamlessly transition to a more integrated community setting.
- TennCare and DIDD will work with ICF/IID providers who desire to repurpose “bed” capacity primarily to meet the transitional stabilization, assessment and planning needs of those with significant co-occurring behavioral health conditions or complex behavior support challenges, as well as those with complex medical needs.
- The reimbursement methodology for ICFs/IID will be restructured to reflect both the higher acuity of individuals receiving these services, and to reflect value-based incentives for specific outcomes that lead to integrated community living.

### Program Expenditure Caps

A program expenditure cap functions as a limit on the total cost of HCBS a person can receive in the home or community setting while enrolled in the applicable HCBS program.

Based on input received, DIDD and TennCare intend to maintain the existing expenditure cap structures currently applicable in each program. No changes are proposed.



We are listening...

No changes are proposed to expenditure caps in any of the programs.



## Support Coordination

High quality Support Coordination is the cornerstone of effective person-centered planning. Today, there are multiple different support coordination (i.e., case management) models in Tennessee’s I/DD delivery system. Based on input received, TennCare and DIDD plan to keep all the current models to support coordination within their existing programs.

- Individuals enrolled in the Statewide and CAC waivers will keep their Independent Support Coordinator (ISC).
- Individuals enrolled in the Self-Determination waiver will keep their DIDD case manager.
- Individuals enrolled in Employment and Community First CHOICES will keep their MCO Support Coordinator.



The efficacy of these models can then be measured by whether they are successful in helping persons supported in making person-centered life choices, utilizing enabling technology to increase their independence, and in achieving employment and community living goals. We can use that information to drive future decisions regarding how best to deliver support coordination in the integrated system.

Payment for ISC agencies would ultimately be driven in part by whether outcomes are in fact achieved. Likewise, we will identify ways to align administrative payments to MCOs for Support Coordination on the same key metrics.

This comparison would be part of the Evaluation Design (required by CMS as part of the 1115 demonstration) for the integrated system, reviewed by an external entity, and shared with other states to help inform future MLTSS design decisions.

## Assessing the Level of Supports Needed

An effective person-centered planning process begins with understanding each person—who they are, what matters to them, and what they want to achieve, as well as the supports they need to be successful in achieving those goals and living the life they choose. Essential to this process is an objective and uniform way to assess each person’s supports needs. The Supports Intensity Scale® (SIS) is a normed and validated instrument created by researchers working with the American Association on Intellectual and Developmental Disabilities (AAIDD) which measures each individual’s support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS was specifically designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals. The SIS is already used in well over 20 states, including Tennessee.

In addition to the SIS, TennCare and DIDD plan to use Tennessee’s Person-Centered Enabling Technology Plan Questionnaire. The Enabling Technology Plan Questionnaire delves deeper into each person’s support needs, with an eye toward potential opportunities where technology may help to increase the person’s independence in or across environments, including home, travel, community, work and volunteering.

### Person-Centered Support Plans (PCSP)

As with other aspects of the new integrated system, the goal as it relates to person-centered planning will ultimately be to achieve alignment across programs. This includes a single PCSP format. TennCare has recently gathered input from providers and other stakeholders and partnered with MCOs to redesign the current PCSP template for Employment and Community First CHOICES, making changes intended to support improved development of individualized measurable outcomes and to track progress toward their achievement. TennCare and DIDD have already begun a process of cross-walking the documents used in each of the existing programs to identify opportunities for alignment. If this cannot be accomplished by July 1, 2021, MCOs will continue to use the newly improved PCSP template for Employment and Community First CHOICES, and DIDD will use the existing ISP template for 1915(c) waivers until such time that a single aligned template can be accomplished.

Even more critical than the template, however, will be alignment of expectations regarding person-centered thinking and planning processes, including quality expectations regarding the planning process and the PCSPs, the usefulness of PCSPs to providers relying on them to support people with IDD, and the individual outcomes that derive from their effective implementation.

DIDD will lead a coordinated approach to quality monitoring and improvement for person-centered plans and planning processes. DIDD will review a sample of each MCO and ISC Agency PCSPs for purposes of quality monitoring and improvement, and for purposes of the evaluation design (described above), and work with each entity to help drive quality improvement. TennCare will conduct this review for DIDD case managers, using the same tool and process.

While MCOs will generally have utilization management authority over PCSPs (meaning review and approval of services), we plan to establish contractual threshold requirements that would trigger a DIDD review/approval as well—primarily focused on ensuring that service denials or reductions are appropriate and that supports are sufficient to meet individual needs and support the achievement of personal goals. These could be based on a threshold amount or percentage—with the specific methodology to be determined in the I/DD Program Operations Agreement. We welcome input regarding these criteria or processes.



**We are listening...**

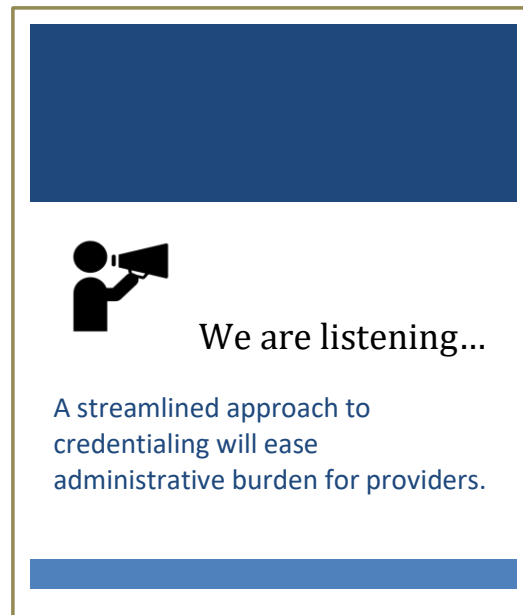
Based on input, DIDD will directly oversee MCO review of person-centered support plans, including service denials or reductions.

## Network Development and Management

Today, there are also multiple different provider networks and approaches to provider enrollment/credentialing/re-credentialing in the I/DD delivery system. Many providers complete four (4) unique enrollment and credentialing processes—five (5) if they also provide ICF/IID services, often requiring much of the same information.

The integration of Medicaid programs and services again provides a unique opportunity to explore a new, streamlined approach to provider credentialing—one that seeks to minimize administrative burden on providers, health plans, and the state, and which seeks to recognize and value those providers who demonstrate the greatest commitment and success in terms of supporting persons with I/DD to achieve desired outcomes.

In this proposed new streamlined approach, DIDD would serve in a “credentialing” role for all HCBS provider types across the I/DD delivery system (with the potential exception of Adult Dental Services). All currently qualified and contracted providers in the 1915(c) waivers (including ISC agencies), currently credentialed and contracted providers in Employment and Community First CHOICES, and certified ICFs/IID would be “deemed” by DIDD as credentialed for participation in the integrated system.



New providers would be credentialed by DIDD using standards established in partnership with DIDD and MCOs, with input from I/DD stakeholders. These would be focused around the “Pillars of Transformation” (see image at left) that will inform values-based provider reimbursement and ultimately drive delivery system transformation.

Under the proposed new credentialing approach, MCOs would be expected to abide by the “deemed” status, and not establish additional requirements or credentialing processes or standards that would again result in multiple different processes.

Likewise, providers would be periodically re-credentialled by DIDD using standards established in partnership with DIDD and MCOs.

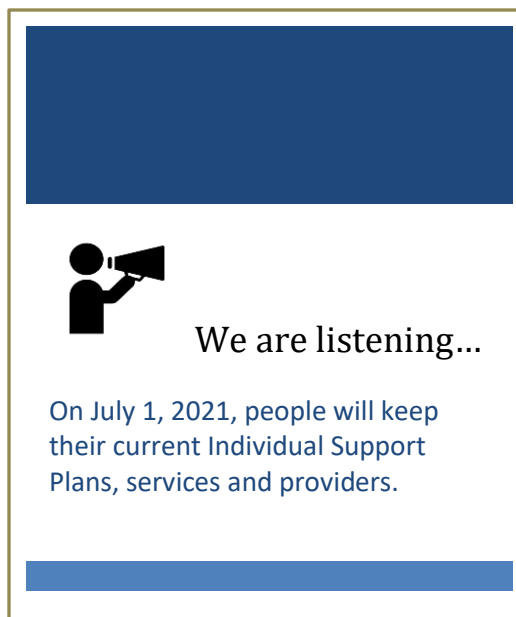
Consistent with the principles of managed care, to ensure that MCOs maintain flexibility to drive quality performance and outcomes, except for continuity of care (described below) and with the potential exception of ISC agencies at least during the evaluation phase (described above), MCOs would not be obligated to contract with all providers “deemed” as credentialed, but could select from “deemed” providers using a set of person-centered “preferred” contracting standards similar to those developed for Employment and Community First CHOICES, but updated based on learning to date and goals of the new integrated system. MCOs would be required to demonstrate network adequacy. This means that a provider could be “deemed” by DIDD to meet credentialing standards, but not selected by any MCO for network participation. This will be an important part of the network management process—ensuring that potential providers fully understand how contracting decisions will be made.

Initially, these standards would function as “preferred standards.” MCOs would be expected to take the “preferred standards” under consideration in developing their networks, and network monitoring would review whether in fact MCO networks demonstrate compliance with this expectation. Over time, we expect that the standards would evolve to “required standards.” After a reasonable period (at least 12 months), providers would be **required** to meet certain standards to continue participation in the program, with additional quality performance standards becoming required over time, while ensuring sufficient capacity to offer choice of providers and timely delivery of services.

While MCOs would generally have authority to build their I/DD networks and would not be obligated to contract with any particular I/DD provider, DIDD would have the authority to ensure an MCO contract with a highly preferred I/DD provider (based on contracting standards) to address identified network gaps—related to the ability to deliver needed services without gaps in care or to address quality (including quality outcome) concerns. In these instances, an MCO would be expected to either contract with an identified provider, or to contract with an alternative provider that is equally preferred and able to fill the identified gap.

### Continuity of Care

Notwithstanding the language above, except for significant quality or compliance concerns, MCOs will be obligated to contract with all 1915(c) providers “deemed” by DIDD to continue the seamless delivery of current services as specified in each person’s approved Individual Support Plan, without gaps in care for at least the first six (6) months following implementation of the integrated I/DD system, or the remainder of their ISP year, whichever is later. This requirement will minimize potential disruptions in care, allow time for effective person-centered planning, and facilitate transition to another provider selected by the person if the current provider will no longer be part of the MCO’s network once the continuity of care period has expired.



We are listening...

On July 1, 2021, people will keep their current Individual Support Plans, services and providers.



### We are listening...

Based on input from providers, we are exploring opportunities for a streamlined authorization, billing and payment system.

Beginning July 1, 2021, provider authorization and billing processes **will not change**—for HCBS and ICF/IID providers. Payments will be made to providers by MCOs.

## Authorizations, Billing and Payment

Today, there are also multiple different provider authorization, billing and payment processes and systems in the I/DD delivery system. Many providers complete four (4) unique billing processes—five (5) if they also provide ICF/IID services.

The integration of Medicaid programs and services provides a unique opportunity to explore a potential new, streamlined approach to provider authorizations, billing and payment—one that seeks to minimize administrative burden on providers, health plans, and the state, and which seeks to ensure that providers have timely access to authorizations, and a consistent user-friendly billing process. It would also ensure continuity across procurement cycles.

This is best achieved through a consolidated system. The PCSP would be developed in or uploaded into this system.

This would allow for DIDD and TennCare to have timely access to all plans of care—for purposes of quality monitoring, reportable event management, overall program review and trending, etc., and perhaps also for purposes of broader care coordination (with PCPs, etc.) PCSP data would drive authorizations that could also flow from the consolidated system. This would provide for ongoing tracking to ensure that authorizations are in fact occurring timely and without gaps. Authorized services would also be used to generate billing templates for providers, indicating each of the services they were authorized to provide for each member, and allowing them to indicate which of the services were in fact provided. This information would be used to generate claims files to the MCOs for processing and payment.

Such a system would ensure a consistent, timely and efficient authorization and billing process for I/DD providers. It would also provide DIDD and TennCare better access to comprehensive program data that could help to drive quality improvement.

While we are exploring potential options to determine if such a system could be purchased or developed, we recognize that such a consolidated system is likely not possible by July 1, 2021. However, due to design decisions related to support coordination processes (described above), DIDD can continue to leverage existing systems and billing processes. Upon receipt of the claims files, TennCare will separate the files by MCO, and forward for processing and payment. ICF/IID providers will continue to utilize the TennCare billing portal, with TennCare directing the claims to the MCOs.

TennCare and DIDD are working together to explore the most efficient and timely options to streamline and consolidate functions across programs going forward. We welcome input regarding these processes.

## Value-Based Reimbursement

One of the most important drivers of delivery system transformation is changes in the way Medicaid payments are made. Thus, a key component of the integrated system will be the implementation of value-based reimbursement for “core” services—primarily residential, day, and personal assistance—to align payment with the achievement of individual and system outcomes.

The successful design and implementation of such an important driver will take time and depend on the active engagement of providers and others. We are establishing such a group— of “*Partners in Innovation*”— that can help to inform this and other system components described in this document. The value-based reimbursement approach ultimately developed will be implemented in an incremental way to ensure the stability of the network, while also building capacity to demonstrate the delivery of improved outcomes for persons supported.

We propose that payments for traditional “day” services would be combined with payments for traditional “residential” services into new payment rates for a more modernized and flexible individualized benefit driven by the needs and preferences of the person. (Employment services would continue to be reimbursed separately at the current levels.)

Based on longstanding feedback from providers, payment for services would be de-linked from staffing ratios. They would also be de-linked from the number of people living in a home, allowing greater flexibility with regard to how best to meet each person’s individualized needs and preferences.

Payment for the newly combined Community-Based Living Supports benefit would be based on the person’s Level of Support, with flexibility across the types of supports that can be leveraged to meet those needs, (including technology-based supports and natural supports as well as paid assistance), and documentation regarding the type of supports to ensure transparency for measuring payments against hours of paid support provided and for purposes of measuring success in achieving individual and program goals. **This will ensure that people who continue to need 24 hours a day of paid assistance will receive such support**, but without an expectation that everyone will have 24 hours a day of paid support when it is not needed, or when other support options (enabling technology, natural supports, etc.) would provide greater freedom and independence. Payment mechanisms such as special needs adjustments would be replaced with reimbursement for additional assistance actually needed and provided, rather than paying for the availability of such assistance “just in case.”



### We are listening....

A values-based reimbursement approach is still in its early development and will likely not be ready by July 1, 2021.

Based on recommendations from the Systems Transformation Leadership Group to we are sharing a proposed framework in order to gather additional input.

Stakeholders will have input, and changes will occur incrementally ensure stability for persons supported and providers.

Funds from the simplification of rate tiers and the move to paying for additional assistance when actually provided could be repurposed to create an incentive structure that will reward providers for actions taken to build their capacity to deliver high quality outcomes and ultimately for the outcomes themselves. This would help to drive the system forward toward the vision of person-centered transformation.

Based on the work of the Systems Transformation Leadership Group, we propose that measurement domains will be aligned with the Pillars of Transformation described in the Network Development section above. By aligning both provider expectations and provider performance around common expectations directly linked to program goals, we are setting providers on a course for individual and program success.

Person-Centered Thinking, Planning and Supports, Technology First, Employment First, Independence and Workforce measurement domains would include both capacity-building and outcome metrics. Capacity-building is intended to support providers in investing in their own organizations in ways that will better position them for success.

- For example, achieving Basic Assurance<sup>©</sup> certification status, becoming a Person-Centered Organization, earning CQL accreditation in person-centered supports and the ultimate accreditation status “With Distinction” create a pathway toward greater expertise in the delivery of high quality, person-centered supports. Individual outcome measures can then assess the direct impact these capacities are having on persons supported by the agency, with incentives based both on organizational (capacity-building) achievements as well as individual outcomes.
- The achievement of professional level certification through APSE or other approved entities by employment staff will better position those staff and the agency to achieve a higher percentage of persons supported working in competitive, integrated employment; increased independence of those individuals on the job (paid supports as a percentage of hours worked and individuals achieving success with only stabilization and monitoring or technology-enhanced assistance); and in upward mobility as measured by increases in hours worked, hourly wage and access to employee benefits—all taking into account individuals’ LOS needs.
- An agency’s attainment of Technology First Organization Certification (ultimately, With Distinction), employing Tech Champions with Enabling Technology Specialist Certificates, and the percentage of DSPs with Enabling Technology credentials fosters a culture within the organization that leads to more people using enabling technology to gain control and independence—in some instances, reducing their reliance on paid supports.

In each of these areas, we would seek to establish and incentivize measures of agency capacity and agency performance which ultimately lead to improved outcomes and better lives for persons supported.

As with Support Coordination, incentives will also be reflected in administrative payments to MCOs, to encourage the development of networks that are best equipped and able to demonstrate person-centered outcomes.

## *Summary*

The proposal outlined and described in this document and the goals we expect it will help to achieve are aspirational and transformational. Implementation will not be instantaneous. Rather, creating a single, seamless person-centered system of service delivery for people with I/DD that empowers their full citizenship is a process that will occur over time.

While it is not possible or responsible to include details on every possible scenario, circumstance or future decision that may be related to the proposal, we will be thoughtful at each step, listening to stakeholders, and building on lessons learned. Most importantly, we will continue to be guided by an unwavering belief that people with disabilities deserve nothing less than the opportunity to live their best lives as full citizens in community and that *every aspect of all of our lives*—our families, neighborhoods, workplaces and communities—will be better because of it.



## Appendix A

### Summary of Proposed Amendments by Authority

## Appendix A: Summary of Proposed Amendments by Authority

<u><b>1115 Demonstration</b></u>	<u><b>1915(c) HCBS Waivers</b></u>	<u><b>Medicaid State Plan</b></u>
Waiver and expenditure authority for the integration of 1915(c) waivers and ICF/IID services into managed care	Include the ECF Working Disabled demonstration group as a Medicaid eligibility category in the waivers—allowing people who are employed to maintain TennCare and waiver benefits	ICF-IID services no longer covered (under the State Plan—coverage moved to 1115 demonstration)
Waiver and expenditure authority for continuation of coverage for current ICF/IID services and new eligibility criteria and informed choice requirement for new ICF/IID admissions (aligned with the ADA)	With ECF Group 8 and newly defined transitional ICF/IID benefit, new enrollment into the CAC waiver also closed	
Waiver and expenditure authority to include people enrolled in a Section 1915(c) waiver in the ECF Working Disabled demonstration group—allowing those who are employed to maintain TennCare and waiver benefits	Person-centered updates in Support Coordination processes and expectations, including Employment Informed Choice process	
Waiver and expenditure authority to add Enabling Technology as a distinct benefit	Add consumer directed options for Statewide and CAC Waivers	
Modifications to criteria for enrollment into TennCare Select to maintain people with I/DD enrolled in SelectCommunity as of 7/1/21	Add Enabling Technology as a distinct benefit	
	Adjustments in therapy, behavior, nutrition and nursing services to maximize efficacy and efficiency	
	Combine residential and most day services into a combined Community-Based Living Supports benefit	
	Values-based changes in reimbursement methodology and expenditure projections for residential and day services	

