



Intellectual/Developmental Disabilities Managed Long Term Services and Supports Programs

Provider Manual Supplement

Tennessee



866-840-4991

<https://providers.amerigroup.com/TN>

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Updates and Changes

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most updated version is available online at <https://providers.amerigroup.com/TN>. To request a free, printed copy of this manual, call Provider Services at **800-454-3730**.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Amerigroup Community Care, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

No person, on the grounds of handicap and/or disability, age, race, color, religion, gender, gender identity, national origin, or any other classification protected under federal or state laws, shall be excluded from participation in, be denied the benefits of or be otherwise subjected to discrimination under any program or service provided in the TennCare program.

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**EMPLOYMENT AND COMMUNITY FIRST (ECF)
CHOICES PROGRAM**

INTRODUCTION

Welcome to the Amerigroup Community Care network provider family! We are pleased to have you in our Tennessee network, which consists of some of the finest health care providers in the state.

This supplement to the Amerigroup Community Care provider manual specifically discusses the I/DD MLTSS Programs which include the Home and Community Based programs: Employment and Community First (ECF) CHOICES, the 1915(c) waivers and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). For information on Medicaid services specifically, please refer to the general Amerigroup provider manual at <https://provider.amerigroup.com/tennessee-provider/home> under Resources >Policies, Guidelines and Manuals. All requirements from the general Amerigroup provider manual apply to the Employment and Community First (ECF) CHOICES, 1915(c) Waiver programs and ICF/IID.

I/DD MLTSS Programs are long-term services and supports for individuals with intellectual or developmental disabilities delivered through the managed care program; refers collectively to the ECF CHOICES programs, the three 1915(c) HCBS waivers, and ICF/IID services. Amerigroup will work with DIDD and TennCare to support all members enrolled in ECF CHOICES, 1915(c) Waiver and ICF/IID Facilities. Amerigroup will coordinate the provision of covered services with services provided by ICF/IID and 1915(c) waiver providers to minimize disruption and duplication of services.

Employment and Community First CHOICES Program

ECF CHOICES is a HCBS program designed to promote and support integrated, competitive employment and independent living as the first and preferred option for all members with intellectual and developmental disabilities (I/DD).

The primary goals of ECF CHOICES are to:

- Support members with I/DD in identifying and meeting their self-identified employment and quality of life goals.
- Provide streamlined, timely access to LTSS services.
- Serve more people with existing LTSS funds.
- Improve coordination of all Medicaid (acute, behavioral and LTSS) services.
- Support families caring for a person with I/DD.
- Improve the experience of each person receiving LTSS, by offering enhanced supports to experience inclusive community living.

CONTACT INFORMATION

Please call Provider Services at 1-800-454-3730 for precertification/notification, health plan network information, member eligibility, claims information, inquiries and recommendations you may have about improving our processes and managed care program. Live Provider Services representatives are available Monday-Friday from 8 a.m.-5 p.m. Central time. You may also use our automated Provider Inquiry Line (IVR) 24 hours a day, 7 days a week, to:

- Check claims status and eligibility.
- Request interpreter services.

Members can call Member Services at **866-840-4991 (TTY 711)** to speak to a live agent Monday-Friday from 7 a.m. to 7 p.m. Central time. Members can also contact the 24-hour Nurse HelpLine for:

- Around-the-clock clinical services.
- Assistance with coordinating behavioral health care needs.

The following are additional resources you may find useful:

- Provider Services fax: **800-964-3627**
- Provider Relations: **800-454-3730**
- Behavioral Health inpatient authorizations: Should be submitted electronically using our preferred method at <https://provider.amerigroup.com/TN>. If you prefer to paper fax, forms are located on the same provider website.
- Behavioral Health outpatient services fax: **866-920-6006**
- Electronic Data Interchange (EDI) Hotline: **800-590-5745**
- Electronic Visit Verification (EVV) Help Desk: **855-329-2116**
- Family Assistance Service Center: **615-743-2000**
- Fraud and Abuse Hotline: **800-433-3982**
- Enhanced HCBS – FMAP Communication:
<https://www.tn.gov/tenncare/long-term-services-supports/enhanced-hcbs-fmap.html>

MEMBER ELIGIBILITY AND ENROLLMENT

Member Screening and Enrollment

Individuals may self-refer to determine ECF CHOICES eligibility by completing the online referral form on TennCare's website at <https://tcreq.tn.gov/tmtrack/ecf/index.htm>.

If the member is unable to complete the referral tool independently or has no natural support to do so on his or her behalf, the member may call Amerigroup at **866-840-4991 (TTY 711)** to speak with a trained managed care organization (MCO) representative who will assist.

Individuals who meet screening criteria will receive a face-to-face intake visit from a support coordinator. All documentation and information obtained will be used to complete an intake packet and determine if the person meets criteria for enrollment.

Enrollment into ECF CHOICES is determined by TennCare and subject to availability of an appropriate slot for the person to enroll.

TennCare will enroll ECF CHOICES members into one of five groups:

Essential Family Supports Benefit Group (Group 4):

- Children under 21 years of age with I/DD living at home, with family who meet the nursing facility level of care (NF LOC) criteria and need and are receiving home and community-based services (HCBS) as an alternative to NF care, or who, in the absence of HCBS, are *at risk of NF placement*
- Adults age 21 and older with I/DD living at home, with family who meet the NF LOC criteria and need, and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are *at risk of NF placement* and elect to be in this group

To qualify for this group, a member must be SSI-eligible or qualify for the ECF CHOICES 217-Like, Interim Employment Community First CHOICES At-Risk Demonstration Group, or, upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

Essential Supports for Employment and Independent Living (Group 5):

- Adults age 21 and older with I/DD who do not meet NF LOC criteria and need, but who, in the absence of HCBS are *at risk of nursing facility placement*

To qualify for this group, the adult must be SSI eligible or qualify for the Interim ECF CHOICES At-Risk Demonstration Group, or, upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

Comprehensive Supports for Employment and Community Living (Group 6):

- Adults age 21 and older with I/DD who meet NF LOC criteria and need and are receiving specialized services for I/DD

To qualify for this group, a member must be SSI eligible or qualify for the ECF CHOICES 217-Like Demonstration Group or, upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group.

Intensive Behavioral Family Supports (Group 7)

Children under age 21 who live at home with family caregivers or other permanent guardian(s) in a long-term family living arrangement, and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at imminent and significant risk of serious physical harm (that does not rise to the level of inpatient treatment or for which such treatment would not be appropriate), significantly strain the family's ability to adequately respond to the child's needs, threaten the sustainability of the family living arrangement, and place the child at imminent and significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration). As a condition of enrollment, the child's family must provide informed consent, including a commitment to actively participate in a family-centered therapeutic approach to treatment and support. The child must meet the nursing facility level of care and need and receive HCBS as an alternative to NF Care. To qualify in this group, a member must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group.

Comprehensive Behavioral Supports for Employment and Community Living (Group 8)

Adults age 21 and older, unless otherwise specified by TennCare, with I/DD and severe behavioral and/or psychiatric conditions, who are transitioning out of a highly structured and supervised environment, meet nursing facility level of care, and need and are receiving specialized services for I/DD. To qualify for enrollment, a person's psychiatric symptoms or behaviors must place the person or others at imminent and significant risk of serious physical harm (that does not rise to the level of inpatient treatment or for which such treatment would not be appropriate), and necessitate continuous monitoring and supervision by 24-hour staff to ensure the person's safety and/or the safety of others. (The intensity of supports needed is expected to lessen as the person achieves stabilization in the community and readies for transition to a different benefit group.) To enroll in this group, a person must be in one of the following target groups: 1) adults with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the member due to the severity and frequency of behaviors; 2) emerging young adults (age 18-21) with I/DD and severe psychiatric or behavioral symptoms aging out of the foster care system; and 3) adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term institutional placement (including residential psychiatric treatment facility). To qualify in this group, a member must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TennCare may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 8, if they meet eligibility criteria.

ECF CHOICES Referrals

Provider selection during the assessment process is member driven. Providers are prohibited from petitioning members to be chosen as the service provider and from petitioning existing ECF CHOICES members to change providers. Additionally, providers are prohibited from communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential ECF CHOICES members that should instead be referred to the person's managed care organization or the Department of Intellectual and Developmental Disabilities (DIDD).

MEMBER BENEFITS AND SUPPORTS

ECF CHOICES Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in ECF CHOICES Groups 4, 5, 6, 7 or 8 as an alternative to long-term care institutional services in a nursing facility, or to delay or prevent placement in a nursing facility. Only certain ECF CHOICES HCBS are eligible for Consumer Direction. ECF CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although home health and private duty nursing services are subject to estate recovery and will, for members enrolled in Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, or Groups 7 or 8 which also have an individual cost neutrality cap, be counted for purposes of determining whether an ECF CHOICES member’s needs can be safely met in the community within his or her individual expenditure cap.

The following services are available to ECF CHOICES members. The table lists the service by a member’s assigned group, which is determined in the comprehensive assessment completed at the time of enrollment and documented in the authorized initial person-centered support plan (PCSP).

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Respite (up to 30 days per calendar year <u>or</u> up to 216 hours per calendar year only for persons living with unpaid family caregivers)	X	X	X		
Supportive home care (SHC)	X				
Family caregiver stipend in lieu of SHC (up to \$500 per month for children under age 18; up to \$1,000 per month for adults age 18 and older)	X				
Community integration support services (subject to limitations specified in the approved 1115 waiver and TennCare rule)	X	X	X	X	
Community transportation	X	X	X	X	
Independent living skills training (subject to limitations specified in the approved 1115 waiver and TennCare rule)	X	X	X	X	
Assistive technology, adaptive equipment and supplies (up to \$5,000 per calendar year of Assistive Technology and Enabling Technology Combined)	X	X	X	X	X
<u>Enabling technology (up to \$5,000 per calendar year of Assistive technology and Enabling technology combined)</u> (Effective 09/01/2021)	X	X	X	X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)	X	X	X	X	X
Community support development, organization and navigation	X			X	
Family caregiver education and training (up to \$500 per calendar year)	X			X	
Family-to-family support	X			X	
Decision-making supports (up to \$500 per lifetime)	X	X	X	X	X

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Health insurance counseling/forms assistance (up to 15 hours per calendar year)	X			X	
Personal assistance (up to 215 hours per month)		X	X		
Community living supports (CLS)		X	X		
Community living supports — family model (CLS-FM)		X	X		
Individual education and training (up to \$500 per calendar year)		X	X		X
Peer-to-peer support and navigation for person-centered planning, self-direction, integrated employment/self-employment and independent community living (up to \$1,500 per lifetime)		X	X		X
Specialized consultation and training (up to \$5,000 per calendar year ¹)		X	X		X
Adult dental services (up to \$5,000 per calendar year; up to \$7,500 across three consecutive calendar years)	X ²	X	X		X
Employment services/supports as specified below (subject to limitations specified in the approved 1115 waiver and in TennCare Rule)	X	X	X	X	X
Supported Employment – individual employment support <ul style="list-style-type: none"> – Exploration – Benefits counseling – Discovery – Situational observation and assessment – Job development plan or self-employment plan – Job development or self-employment start up – Job coaching for individualized, integrated employment or self-employment – Coworker supports – Career advancement 	X	X	X	X	X
Supported employment (small group supports)	X	X	X	X	X
Integrated employment path services	X	X	X	X	X
Intensive behavioral family-centereded treatment, stabilization, and supports (IBFCTSS)				X	
Intensive behavioral community transition and stabilization services (IBCTSS)					X

ECF CHOICES members may choose to participate in the Consumer Direction program, in which they hire, fire and supervise workers’ specific HCBS functions. For more details, see the Consumer Direction section.

¹ For adults in the Group 6 benefit group determined to have exceptional medical and/or behavioral support needs, and for adults in Group 8, specialized consultation services are limited to \$10,000 per person per calendar year.

² Limited to adults age 21 and older.

Effective November 2, 2021, through March 31, 2024, ECF CHOICES Groups 4, 5, 6, and 7 members will be eligible to exceed benefit limits in order to be receive a one-time total increase of up to \$3,000 across the following services:

- Respite
- Assistive Technology, Adaptive Equipment and Supplies
- Enabling Technology
- Minor Home Modifications

The \$3,000 is a one-time total increase that may be utilized anytime between November 2, 2021, and March 31, 2024. A member may elect to receive additional units of one service or multiple services; however, the overall limitation on additional services is \$3,000 per person. This assistance is provided in addition to existing service limitations and without regard for expenditure caps or individual cost neutrality tests specified in the approved waiver.

To qualify for this additional assistance the individual must be enrolled in the ECF CHOICES program as of July 12, 2021, living with family members who routinely provide unpaid support and assistance; or if the individual does not live with family members, must have unpaid family caregivers who routinely provide unpaid support and assistance. The person may not be receiving residential supports.

The availability of these additional benefits is expected to support the person's independence, support family caregivers, address the additional stresses from impacts of COVID-19, and ensure the sustainability of these supports going forward.

Except as outlined above, all other policies applying to benefit limits in ECF CHOICES continue to apply.

Short Term Stay (STS) Benefit in ECF CHOICES

In addition to the benefits specified above which will be delivered in accordance with the definitions, including limitations set forth in the approved 1115 waiver and in TennCare rule, a member enrolled in ECF CHOICES Groups 4, 5, and 6 may, subject to requirements described within the Contractors Risk Agreement (CRA) section 2.9.7.3.27.11, receive short-term care (i.e., no more than ninety (90) days) in a NF or ICF/IID, without being required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within ninety (90) days from admission. A member enrolled in ECF CHOICES Groups 7 and 8 will not be eligible to receive short-term care in a NF or ICF/IID.

Amerigroup will review all requests for short-term NF or ICF/IID stays and will authorize and/or reimburse short-term NF or ICF/IID stays for Groups, 4, 5 and 6 members only when (1) the member is enrolled in ECF CHOICES Group 4, 5, or 6 and receiving HCBS upon admission; (2) the member meets the applicable institutional level of care in place at the time of admission (NF level of care for a short-term NF stay and ICF/IID level of care for a short-term ICF/IID stay); (3) the Member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to receiving ECF CHOICES HCBS in the community upon its conclusion; (5) with regard to short-term NF care, the PASRR process is complete, the person's short-term stay is appropriate, and all applicable specialized services have been arranged; and (6) DIDD has reviewed and approved the request *prior* to admission and the start of the short-term stay in a NF or ICF/IID for any member with I/DD in an HCBS setting unless the STS follows hospitalization for a medical condition and discharge to a NF for STS is for rehabilitation or recovery of the same condition as treated in the hospital. In this case only notification to DIDD is required. Amerigroup will provide such notification to DIDD within five (5) business days of the person's admission to the NF, or of knowledge of such admission if the CONTACTOR is not notified until after admission occurred.

Within fifteen (15) days of admission for an STS to a NF or ICF/IID (or knowledge of the admission if Amerigroup not notified until after the admission occurred), Amerigroup will work with the member (and his/her representative, as applicable) to develop and submit a transition plan to DIDD for review and approval. If the member (or his/her health care representative) is unwilling to engage in transition planning, Amerigroup will continue to engage the member on each subsequent visit. Amerigroup will monitor all short-term NF and ICF/IID stays for Group 4, 5, and 6 members and will provide all documentation requested by TENNCARE to ensure that the member is disenrolled from ECF CHOICES if a) it is determined that the stay will not be short-term, or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF or ICF/IID benefit. A person enrolled in ECF CHOICES Groups 7 or 8 is not eligible for a short-term NF stay and must be disenrolled from ECF CHOICES in order to receive Medicaid-reimbursed NF or ICF/IID services.

Electronic Visit Verification System

Electronic Visit Verification (EVV) System — an electronic system used to monitor a Member’s receipt and utilization of certain ECF CHOICES based services. Our current EVV vendor is CareBidge*. Provider staff arrival and departure are captured through the use of a static GPS device in EVV.

The system acts as verification that services are being performed within the Member’s preferred schedule, approved location and must also be utilized by the provider for submission of claims.

To use the EVV system, providers check in using a GPS tablet device at the Member’s home promptly upon arrival. The provider’s employee may download the Amerigroup EVV application to their own Android or Apple smartphone at no charge, which may be used for checking in and out of a visit if the Member’s tablet is not available. This confirms the identity of the individual provider/staff worker, as well as the arrival time and location. If neither of these options are available, the caregiver can utilize the Member’s phone to check in. At the end of the shift or assignment (and prior to leaving the Member’s home), the provider/staff worker will check out using the tablet device, or the same method in which the check in occurred, logging the departure time and completing a brief survey. This survey will only be available via the tablet method for checking out. If a provider/staff worker fails to check in at the appropriate time, the EVV system will alert Amerigroup and steps will be taken to ensure the member receives the appropriate care at the appropriate time. At a minimum, providers should have at least one full-time staff person devoted to EVV system monitoring, including after hours and weekends, if a member is scheduled to receive care, and two staff persons fully trained and knowledgeable of the EVV system and its functionality. Use of this system is compulsory by providers administering HCBS services to members covered by Amerigroup.

Direct Support Professionals (DSP) are the first line of sight into tablet issues. Please be sure to communicate any issues with the tablet and/or other methods of check in/out with the EVV team. Notify Amerigroup immediately via the Get Support function in the EVV system or by sending an email to the provider request mailbox at Itcprovreq@amerigroup.com when a member has been identified as having no method to check in/out. This includes if the tablet is not available, the tablet is unable to be turned on, the tablet is not receiving a signal, the tablet is broken, the caregiver is unable to use the mobile application for check in/out or the member receiving care does not have a phone the DSP can use to check them in/out. Amerigroup will document the member as having no eligible method to check in/out after validating that none of the methods are available. This status will not be permanent and will be revalidated on a monthly basis.

Providers are responsible for complying with the following EVV system processes:

- Log the arrival and departure of the provider/staff worker

- Verify that services are being delivered at the correct location (e.g., the Member’s home) and at the appropriate time
- Verify the identity of the provider/staff worker providing the service to the member
- Match the services provided to a member with the services authorized in the person-centered support plan
- Ensure adherence to the established schedule of services
- Ensure that the provider/staff worker delivering the service is authorized to deliver such services
- Establish a schedule of service delivery with as much flexibility and/or specificity within the authorization and program rules as the member wants and needs. Identify the time each service is needed including the amount, frequency, duration and scope of each service
- Provide notification to the EVV team if a worker does not arrive as scheduled or otherwise deviates from the authorized schedule; this ensures service gaps and the reason the service was not provided as scheduled are identified and addressed immediately, and backup plans are implemented as appropriate
- Keep the late/missed visit (LMV) dashboard up-to-date and accurate. Visibility of LMV entries is lost after seven calendar days from the dashboard. This information is used for a state report and must be accurate
- Generate claims for submission to Amerigroup
- Capture worker/member surveys
- Manage all tablets assigned to members under their care

Amerigroup requires contracted providers to use the EVV system for applicable services. Contracted providers must have at least two staff persons fully trained on the EVV system who can train Direct Support Professionals (DSPs) on using the device in the Member’s home. An additional expectation is that at least one staff person with the contracted provider is dedicated to monitoring caregiver activity to ensure that DSPs are in the Member’s home providing services at the scheduled time agreed upon when the referral was accepted.

It is imperative providers comply with these standards to ensure members are receiving services in a timely manner. To maintain acceptable compliance scores, it is required for 90% (or more) of scheduled services submitted for payment to have GPS coordinates attached. Provider compliance with appointment staffing will be monitored on an ongoing basis. Providers are required to submit member specific late and missed information to the MCO for TennCare monthly reporting. Providers that have not met the minimum performance requirements are subject to corrective action plans (CAP) to include moratorium for new referrals and imposing financial sanctions (pass through liquidated damages). Continued non-compliance after the completion of CAP may result in reinstatement of the CAP or additional action including up to termination.

Performance Metrics for Provider Compliance

Staffed appointments

Provider compliance is determined by calculating the number of on-time appointments staffed by the provider and dividing by the total number of appointments for a member over the calendar month.

Example:
 100 total appointments
 Five missed visits
 Five late visits
 90 on-time visits
 $90/100 = 90$ percent compliance score

Manually confirmed visits

A manual confirmation is submitted by the provider in order to be paid for a visit that is late, missed, visit length deviates from authorization, no authorization on file, split visits, more than 1 worker per visit, or when no check-in/out is recorded for the member.

- Note: Check-ins/outs outside of the Member’s radius will result in a manual confirmation as they will not associate with the member.
- A manual confirmation will also be required to use respite services. This is the only service that is not available for check in/out.

Manually confirmed visits are appointments for which the provider had to request and submit manual confirmations to Amerigroup for approval. Manual confirmations are instances in which the provider submits scanned time sheets requesting approval of time submitted. Submissions of manual confirmations should be a last resort. If manuals are being submitted, Amerigroup must have on file within the Member’s EVV record an explanation of why the tablet, bring your own device (BYOD) and telephony options of check in/out cannot be utilized by the caregiver.

Time sheets are required to contain the below items when submitted with a manual confirmation:

- Name of the member receiving services
- Signature of the member or an authorized representative
- Time services were rendered/duration of care — A.M./P.M. designation should be included
- Date services were rendered
- Tasks performed
- Name of caregiver performing services
- Name and/or logo of provider submitting time sheet

Any visit confirmed without any use of EVV for clocking in or clocking out that is within the provider’s control is considered noncompliant and manually confirmed. Continued submission of manual confirmations without an approved, documented reason will be subject to a CAP. Amerigroup will measure manual confirmation compliance by dividing the total number of manually confirmed visits by the total number of visits over the calendar month.

Example:

100 total appointments
Five manually confirmed visits
95 GPS/telephone confirmed visits
 $95/100 = 95\text{-percent compliance score}$

Providers that have not met the minimum performance requirements are subject to Corrective Action Plans (CAP) to include moratorium for new referrals and imposing financial sanctions (pass through liquidated damages). Continued non-compliance after the completion of CAP may result in reinstatement of the CAP or additional action including up to termination.

Missed visit reason code/resolution status

It is the provider’s responsibility to maintain the appropriate selection of reason codes/resolution statuses for all missed visits via the EVV system dashboard. This will be monitored through results from missed visits without reason codes/resolution statuses populated in an appropriate or timely manner. Providers have access to enter reason codes/resolution statuses up to seven days after the appointment date. Failure to submit a reason

code/resolution status will result in an automated blank submission and will be added to the numerator in the missed visit calculation. Scores will be calculated as the total missed visits with reason codes/resolution statuses divided by the total number missed visits as applicable.

Example:

100 total missed visits
Five missed visits with blank reason codes/resolution statuses
95 missed visits with reason codes/resolution statuses
 $95/100 = 95$ percent compliance score

Providers that have not met the minimum performance requirements are subject to Corrective Action Plans (CAP) to include moratorium for new referrals and imposing financial sanctions (pass through liquidated damages). Continued non-compliance after the completion of CAP may result in reinstatement of the CAP or additional action including up to termination.

Late Missed Visits (LMV) reports

The Division of TennCare updated its late/missed visits (LMV) monthly reporting requirements. LMV data is sent to the Division of TennCare on a monthly basis. Provider agencies who use the electronic visit verification (EVV) platform and who bill for services on behalf of TennCare CHOICES and ECF CHOICES members are required to submit specific member information regarding the LMV.

Amerigroup Community Care sends a report to each agency with a response due date. The provider agency populates the report with the following information and returns the report to Amerigroup by the specified due date:

- If the visit was late:
 - Time the late visit was initiated
 - Brief explanation of follow-up actions taken by the provider to prevent future late visits
- If the visit was missed:
 - Confirmation of whether the visit was made up or not
 - If the visit was made up, date and time the missed visit was made up
 - If the visit was not made up, explanation of why the visit was not made up
 - Confirmation whether the Member's backup plan was initiated
 - Brief explanation of the follow-up actions taken by the provider to prevent future missed visits

Best practices for providers:

- Keep your LMV dashboard up to date and accurate. You will lose visibility of LMV entries seven calendar days after any appointment is late or missed. This information is used for a state report and must be accurate.
- Stay on top of your manual confirmations to ensure they show your appointments as on time or having a late check-in so staffing information and the reasons for an LMV are accurate.
- Use the Notes section within the appointment to capture comments regarding documentation needed to respond to late or missed visits.

Tips for completing the LMV report:

- Ensure that the provider agency email address for LMV data is correct. Updated email addresses can be sent to the EVV mailbox at tn1tcevvcs@anthem.com.
- Do not make changes to prefilled cells.

- Do not change the format of the document. The document should be returned in Excel format via email.
- Do not send the Excel file as a secure email.
- Responses must provide accurate information as well as specific details regarding the appointment. Generic answers for each member are not acceptable.
- Check both the late and missed visit tabs within the request.
- Responses must be professional, free of spelling errors and grammatically correct.

Responses must be accurate information and provide specific details regarding the appointment. Generic answers for each member are not acceptable. Documentation submitted by the provider will be sent to the Division of TennCare exactly the way the MCO receives it. If no response is received from the provider, this will be documented and sent to the Division of TennCare as well. Providers who do not comply are subject to a *Corrective Action Plan (CAP)*, including moratoriums for new referrals and financial sanctions (liquidated damages). Continued noncompliance after the completion of a *CAP* may result in reinstatement of the *CAP* or additional action, up to and including termination.

Measuring Compliance Criteria

Amerigroup monitors the following criteria to determine provider agency compliance:

- **Late and Missed Visit reporting:** Provider Late and Missed Visit Reports not received within the required timeframe.
- **Late and Missed Visit reporting:** The responses on the Provider Late and Missed Visit Reports are incomplete or inaccurate.
- **Manual Confirmation percentage below compliance standard:** 90 percent
- **Missed Visit percentage below compliance standard:** 90 percent
- **Late Visit percentage below compliance standard:** 90 percent

TennCare-MCO Contractor Risk Agreement (CRA) Amendment 11 changes the previous manner in which Liquidated Damages (LD) will be assessed. Liquidated Damages will be assessed to the MCO based on provider and MCO driven late visits, missed visits and visits that are manually-confirmed. Providers must meet at least 90% compliance for late visits, missed visits, check ins and check outs. LDs will be assessed at \$5,000 and up per provider per month for EACH noncompliant metric. If a provider agency is deemed noncompliant due to late, missed and manually confirmed visits the MCO may opt to pass through liquidated damages that are assessed as stated in your provider manual supplement and agreements.

TennCare **may** opt, at its discretion, to apply a \$500 per occurrence assessment in lieu of the methodology described above in addition to the cost of services not provided (if missed) and the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act. The MCO may opt to pass through these penalties as well.

TennCare-MCO CRA Amendment 11, has been updated to the following LDs based on the percentage of noncompliance with **each** metric (provider-initiated late visits, missed visits, manual confirmations):

- \$5,000 per month that 11-15% of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS
- \$10,000 per month that 16-20% of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS
- \$15,000 per month that 21-25% of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS
- \$20,000 per month that 26-30% of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS

- \$25,000 per month that 31% or more of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS

The EVV system will provide contracted HCBS providers with the following billing-related services:

- **Invoices** – electronic 837i invoices in the format approved by Amerigroup
- **Billing maintenance reviews** – ability to review and perform maintenance, as necessary, to all billing prior to submission
- **Billing maintenance reports** – reports of billing items and edits made to billing items (this information will also be provided to Amerigroup)

All the server hardware and software needed to run the EVV system is provided through multiple redundant data centers. Users access the system through a secure website. The recommended user setup includes:

- Microsoft Windows XP, Vista
- Internet Explorer version 7 or later or Firefox 3.5 or later
- Video card that supports 1024 x 768, 16-bit
- Pentium D 2 gigahertz (GHz) processor (or better)
- 1 gigabyte (GB) of random-access memory (RAM), or better (2 GB of RAM for Vista)
- 1 GB of free hard-disk space

These requirements guarantee the fastest connectivity and greatest user satisfaction. Agencies that do not currently meet the recommended requirements will still be able to access the system, provided they have access to the Internet.

Support Coordination

All ECF CHOICES members are assigned a support coordinator. The support coordinator's primary responsibility is to provide individualized member support through a coordinated multidisciplinary approach that includes the allocation of appropriate resources, identifying community resources, coordinating care with community support agencies, monitoring compliance based on the Member's needs, member education and other resources as necessary for the member. Amerigroup uses support coordination to continually:

- Assess a Member's physical, behavioral, functional, and psychosocial needs
- Develop a Member's person-centered support plan based on the Member's choices, preferences and support needs (for more information see the [Person-Centered Support Plan \(PCSP\)](#) section)
 - For members enrolled in ECF CHOICES Groups 7 or 8, person-centered planning processes shall be conducted by the Integrated Support Coordination Team which includes an assigned Support Coordinator
- Identify and authorize physical health, behavioral health, LTSS and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs contained in the person-centered support plan
- Ensure timely access to and provision for coordinating and monitoring of physical health, behavioral health and LTSS services needed, to help the member maintain or improve his or her physical or behavioral health status/functional abilities and maximize independence
- Facilitate access to other social support services and assistance needed in order to ensure the Member's health, safety, and welfare and, as applicable, to delay or prevent the need for more expensive institutional placement
- Explore employment options and ways to be a part of the community and build relationships

- Determine which services and supports are needed to meet the Member’s needs and reach their self-identified quality of life goals
- Develop and access other services and unpaid supports
- Understand all of the services and providers settings available
- Assist members in selection of services, service providers and settings where the services will be provided

Amerigroup will ensure that the provider understands the role of the support coordinator and has their contact information. Providers and DSPs are expected to notify a Member’s support coordinator in a timely manner of any significant changes to a Member’s condition, care needs, or hospitalizations. Amerigroup will train key provider leadership and DSPs about the importance of this communication with the support coordinator.

Note: The member identification card indicates if a member is enrolled in ECF CHOICES.

Ongoing Support Coordination

Amerigroup strives to identify and immediately respond to problems and issues, including circumstances that would impact the Member’s ability to continue living in the community. Amerigroup provides the following ongoing support coordination:

- During the annual update to the PCSP , discuss participation in the Consumer Direction program when eligible ECF CHOICES HCBS are included (see the [Consumer Direction](#) section for more details)
- Complete the Employment Informed Choice process
- Complete the Employment Data Sheet (EDS) during a face-to-face visit or telephonically at least annually
- Review the Member’s progress toward employment and/or community integration goals
- Educate the member about his/her ability to use advance directives, and document the Member’s decision in the Member’s file
- Ensure the PCSP addresses the Member’s desired outcomes, needs and preferences
- Document and confirm the Member’s address and telephone numbers
- Determine whether the cost of ECF CHOICES HCBS, excluding minor home modifications (for members in Group 4 only) will exceed the Member’s expenditure cap
- Educate the member about their expenditure cap
- Provide the member with information about potential providers when new services are added to the PCSP
- Monitor services to ensure services are initiated and continued as defined in the PCSP (including monitoring the EVV system)
- Identify and address service gaps, ensuring that back-up plans are implemented and working effectively
- Reassess, at least annually, the Member’s needs and update their PCSP by reviewing modifications to a member’s rights under the HCBS Settings Rule
- Conduct an individual experience assessment (IEA), at least annually, with the member to ensure compliance with the HCBS Settings Rule
- Maintain appropriate ongoing communication with community and natural supports to monitor and support their ongoing participation in Member’s care
- Coordinate with community organizations that provide services that are important to the health, safety, and well-being of members
- Identify and immediately respond to problems and issues, including circumstances that would impact the Member’s ability to continue living in the community
- Identify changes to Member’s risks and address changes

- Conduct a level of care reassessment at least annually, and within five business days of Amerigroup becoming aware that the Member’s functional or medical status has changed in a way that may affect level of care eligibility
- Notify TennCare immediately if a Member’s needs cannot be met safely in the community and within their expenditure cap
 - At a minimum, Amerigroup will consider the following a significant change in needs or circumstances for members in ECF CHOICES residing in the community:
 - Change of residence or primary caregiver
 - Loss of essential social supports
 - Significant change in health and/or functional status
 - Loss of mobility
 - An event that significantly increases the perceived risk to a member
 - Referral to Adult Protective Services (APS) or the Department of Children’s Services (DCS) because of abuse, neglect, or exploitation
 - Loss of employment or change in employment status

Amerigroup facilitates timely communication between internal departments and the support coordinator to ensure that each support coordinator receives all relevant information about their members (e.g., member services, population health, utilization management and claims processing). The support coordinator will follow up on this information as appropriate (e.g., documenting this information in the Member’s PCSP, monitoring of outcomes, and, as appropriate, conducting a needs reassessment and updating the PCSP).

Amerigroup will monitor and evaluate a Member’s emergency department and behavioral health crisis service utilization to determine the reason for these visits. The support coordinator will facilitate appropriate utilization of these services (e.g., communicating with the Member’s providers, educating the member, conducting a needs reassessment, updating the Member’s PCSP to better manage the Member’s physical health or behavioral health condition[s] and/or providing a referral for behavioral crisis prevention, intervention and stabilization services if medically necessary).

Support coordinators working with an ECF CHOICES member receiving system of support (SOS) services will participate as a member of the SOS team to ensure that the crisis prevention, intervention and stabilization plan is incorporated in the PCSP.

Support coordinators are actively involved in discharge planning when an ECF CHOICES member is admitted for an inpatient stay. Hospitalized ECF CHOICES members receive face-to-face visits to complete a needs reassessment and update the Member’s PCSP as needed. The following will be documented at each face-to-face visit:

- Whether a copy of the PCSP is accessible in the home to all DSPs
- Whether the PCSP is being implemented and services are being delivered in a manner that is consistent with the Member’s preferences, and supports the member in achieving his or her goals and desired outcomes
- When the Member’s PCSP includes management of member funds by a provider: a review of financial records and statements to ensure bills have been paid timely and are not overdue, and that there are adequate funds remaining for necessary expenses

Minimum Support Coordinator Contacts

The support coordinator will conduct and document, in writing, all needs assessments, support planning activities and minimum support coordinator contacts as specified below in the Member’s place of residence,

except under extenuating circumstances (e.g., during the Member’s hospitalization or upon the Member’s request).

For ECF CHOICES Groups 7 and 8, the Integrated Support Coordination Team (ISCT) shall consist of the Member’s Support Coordinator and the Amerigroup Behavior Supports Director (or a similarly qualified behavior supports professional). The ISCT shall be responsible for performing support coordination functions, including (but not limited to) comprehensive initial and ongoing assessments, development and implementation of the PCSP, monitoring progress and outcomes, and transition planning.

Support coordinators assess the contact required to meet the Member’s need and ensure the Member’s health and welfare. Support coordinators will contact their ECF CHOICES members according to the following time frames:

ECF CHOICES group	Contact details
Groups 4, 5 and 6	Within five business days of enrollment into ECF CHOICES; face-to-face contact to initiate comprehensive assessment, conduct caregiver assessment and authorize services on the initial support plan
Groups 4, 5 and 6	Within five calendar days of completion of outcome-based employment services; telephone contact to reassess service needs
Groups 4, 5 and 6	Within five business days of the support coordinator becoming aware of a Member’s functional/medical status change that may affect level of care eligibility; face-to-face contact
Groups 4, 5 and 6	Within five calendar days of notification that a member is admitted into an inpatient facility (hospital and/or nursing facility); face-to-face contact
Groups 4, 5 and 6	On a monthly basis during the Consumer Direction implementation process when no interim services are in place for the member; face-to-face contact
Groups 4, 5 and 6	On a monthly basis when the member is admitted to a short-term (90 days) nursing facility stay; face-to-face contact
Groups 4, 5 and 6	On an annual basis (from the date of initial assessment) to complete annual assessment and level of care assessment; face-to-face contact
Groups 4, 5 and 6 <i>(upon Money Follows the Person [MFP]* transition at the conclusion of his 365-day participation period)</i>	<ul style="list-style-type: none"> • Within 24 hours when members live alone or at elevated risk; face-to-face contact • Within 24 hours when a member lives with caregiver; telephone contact, then face-to-face within 7 calendar days. • Then, on a monthly basis: <ul style="list-style-type: none"> ○ Face-to-face contact for months 1-3 ○ Face-to-face contact or telephone contact for months 4-12 (face-to-face contact required every 90 days)
Groups 4, 5, 6, 7 and 8	<ul style="list-style-type: none"> • Shall visit the member face-to-face within five (5) business days of becoming aware that the member has a significant change in needs or circumstances as defined in Section A.2.9.7.11.2.1.17. The Support Coordinator shall assess the Member’s needs, conduct a comprehensive assessment and update the Member’s PCSP to accurately reflect any changes in the Member’s circumstances and any impact on the Member’s needs, as deemed necessary
Groups 5 and 6 <i>(with community living supports [CLS] housing,</i>	<ul style="list-style-type: none"> • Within 24 hours; telephone contact • Within 7 calendar days; face-to-face contact • On a monthly basis thereafter; face-to-face contact

ECF CHOICES group	Contact details
<i>upon transition to CLS home)</i>	<ul style="list-style-type: none"> On a monthly basis, if receiving Community Living Supports (CLS)
Group 4	<p>Members in ECF CHOICES Group 4 shall be contacted by their support coordinator in person or by telephone at least quarterly (i.e., the Member’s support coordinator must complete each subsequent contact within 90 calendar days of the previous contact). These members shall be visited in their residence face-to-face by their support coordinator at least semi-annually (i.e., the Member’s support coordinator must complete each subsequent face-to-face visit within 180 calendar days of the previous visit). Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the member’s needs and/or request which shall be documented in the PCSP or based on a significant change in needs or circumstances.</p>
Group 5	<p>Members in ECF CHOICES Group 5 shall be contacted by their support coordinator in person or by telephone at least monthly (i.e., the Member’s support coordinator must complete each subsequent contact within 30 calendar days of the previous contact). These members shall be visited in their residence face-to-face by their support coordinator at least quarterly (i.e., the Member’s support coordinator must complete each subsequent face-to-face visit within 90 calendar days of the previous visit). Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the Member’s needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.</p>
Group 6	<p>Members in ECF CHOICES Group 6 determined by an objective assessment to have low to moderate need and not to have exceptional medical or behavioral needs shall be contacted by their support coordinator at least monthly either in person or by telephone (i.e., the Member’s support coordinator must complete each subsequent in person or telephone contact within 30 calendar days of the previous contact). These members shall be visited in their residence face-to-face by their support coordinator at least bimonthly (i.e., the Member’s support coordinator must complete each subsequent face-to-face visit within 60 calendar days of the previous visit). Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the member’s needs and/or request which shall be documented in the PCSP or based on a significant change in needs or circumstances.</p> <p>Members in ECF CHOICES Group 6 determined by an objective assessment to have high need and members in ECF CHOICES Group 6 determined by an objective assessment to have exceptional medical or behavioral needs (including members with low to moderate need who have exceptional medical or behavioral needs) shall be visited in their residence face-to-face by their support coordinator at least once a month (i.e., the Member’s support coordinator must complete each subsequent face-to-face visit within 30 calendar days of the previous visit). More frequent face-to-face and/or telephone contacts shall be conducted when appropriate based on the Member’s needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.</p>

ECF CHOICES group	Contact details
Group 7	<p>During at least the first month of enrollment in ECF CHOICES Group 7, the thirty (30) days leading up to any planned transition out of ECF CHOICES Group 7, and the thirty (30) days following transition out of ECF CHOICES Group 7 into another ECF CHOICES Group, members shall be contacted by their Integrated Support Coordination Team (ISCT) at least weekly either in person or by telephone or other form of audio/visual communication requested by and available to the member(i.e., the Member's ISCT must complete each subsequent contact within seven (7) calendar days of the previous contact). A minimum of at least one weekly contact shall continue until IBFCTSS services are in place and for at least the first two weeks following the initiation of IBFCTSS services. These members shall be visited in their residence face-to-face by their ISCT at least monthly (i.e., the member's ISCT must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit). Face-to-face and/or telephonic or other non-in-person contacts as requested by the member shall be conducted more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances. The Support Coordinator and the Behavior Supports Director (or similarly qualified member of the ISCT) shall be present for all minimum face-to-face contacts.</p>
Group 8	<p>During at least the first month of enrollment in ECF CHOICES Group 8, during the thirty (30) days leading up to any planned transition out of ECF CHOICES Group 8 and the thirty (30) days following transition out of ECF CHOICES Group 8 into another ECF CHOICES Group, members shall be contacted by their ISCT at least weekly either in person or by telephone or other form of audio/visual communication requested by and available to the member (i.e., the Member's ISCT must complete each subsequent contact within thirty (30) calendar days of the previous contact). A minimum of at least one weekly contact shall continue until IBCTSS are in place and for at least the first two weeks following the initiation of IBCTSS. These members shall be visited in their residence face-to-face by their ISCT at least monthly (i.e., the Member's ISCT must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit). Face-to-face and/or telephonic or other non-in-person contacts as requested by the member shall be conducted more frequently when appropriate based on the Member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances. The Support Coordinator and the Behavior Supports Director (or similarly qualified member of the ISCT) shall be present for all minimum face-to-face contacts.</p>

* The Money Follows the Person (MFP) Rebalancing Demonstration assists eligible members living in a qualified institution transition to a qualified residence in the community.

Person-centered Support Plan (PCSP)

For all members in ECF CHOICES, the support coordinator will develop a written plan called the person-centered support plan (PCSP).

The support coordinator develops the PCSP using a person-centered planning process that accurately documents the Member's strengths, needs, goals, lifestyle preferences and other preferences, and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals and meet their identified unmet needs. To determine the services that will be provided, the support

coordinator considers the availability and role of unpaid supports provided by family members, as well as other natural supports through paid services provided by us and other payer sources.

The person-centered planning process is directed by the member unless he or she has a court appointed guardian or conservator. It may include a representative whom the member has freely chosen to assist with decision-making and others chosen by the member to contribute to the process. This planning process (and the resulting PCSP) will assist the member with:

- Achieving outcomes and a personally defined lifestyle in the most integrated community setting possible
- Ensuring delivery of services in a manner that reflects personal preferences and choices
- Contributing to the assurance of health, welfare and personal growth

Note: The support coordinator will review the documentation and specify the member representative types, as well as the decisions he/she is authorized to make.

Within 30 calendar days of notice of ECF CHOICES enrollment, the support coordinator will update the PCSP with the following:

- Member's profile including what the member likes about self, what is important to the member and how best to support the member
- Member demographics including natural supports, legal representation, any other primary contact and current medical providers
- Descriptions of the Member's:
 - Visions related to career and employment, as well as identified ongoing needs for education and learning
 - Ongoing and identified needs for relationships, natural supports and community membership
 - Home setting, including any accommodations or home modifications made or needed to ensure member safety
 - Mode of communication, including a description of any special communication needs
 - Personal funds management preferences, including any payee, goals and supports needed
 - Physical and behavioral health conditions, and functional status (i.e., areas of functional deficit); and the Member's physical, behavioral and functional needs
 - Medical equipment used or needed (if applicable)
 - Back-up plan
 - Emergency/disaster plan
- HCBS Settings Compliance, including a list of restrictions/justifications, less restrictive alternatives attempted and their outcomes and reevaluating process of restriction
- Unpaid and natural supports that can assist the member with tasks or support
- ECF CHOICES service(s) that will be provided to the member
- Frequency of planned support coordinator contacts needed, which will include consideration of the Member's needs and circumstances.
- An attachment of the:
 - Behavior support plan, if applicable

The Member's support coordinator and coordination team will ensure that the member reviews, signs and dates the PCSP and any updates thereafter. If a member refuses to sign the PCSP because they are: requesting less/more services; a different type of service; or an increased amount, frequency, scope and/or duration of services than what is included in the PCSP, Amerigroup will, in the case of a new PCSP, authorize and initiate

services in accordance with the PCSP. In the case of an annual or revised PCSP, Amerigroup will ensure continuation of at least the level of services in place at the time the annual or revised person-centered support plan was developed until a resolution is reached, which may include resolution of a timely filed appeal.

Amerigroup will not use the Member's acceptance of services as a waiver of the Member's right to dispute the PCSP or as cause to stop the resolution process.

The Member's support coordinator/support coordination team will:

- Provide a copy of the Member's completed PCSP to the member, the Member's representative and the Member's community residential alternative provider, as applicable. Updates to the PCSP should also be distributed in this way.
- Provide copies to other providers authorized to deliver care to the member upon request.
- Ensure providers who do not receive a copy of the PCSP are informed, in writing, of all relevant information needed to provide quality care for the member and to help ensure the Member's health, safety and welfare, including the tasks and functions to be performed.

Within five business days of completing a reassessment of a member's needs, the Member's support coordinator/support coordination team will update the Member's PCSP as appropriate, and authorize and initiate HCBS services in the updated PCSP.

The Member's support coordinator will inform each member of his or her eligibility end date and educate members regarding the importance of maintaining TennCare ECF CHOICES eligibility, renewing eligibility at least once a year, and being contacted by TennCare or its designee near the date of a redetermination to assist them with the process (e.g., collecting appropriate documentation and completing the necessary forms).

Consumer Direction

If, during the needs assessment/reassessment process, the support coordinator determines the member needs specified types of ECF CHOICES HCBS including personal assistance, supportive home care, respite and community transportation, the member may participate in the Consumer Direction program. Eligible ECF CHOICES HCBS do not include home health, private duty nursing services, or Intensive Behavioral Family-Centered Treatment, Stabilization, and Supports (IBFCTSS). Self-direction of health care task is an option for individuals participating in consumer direction to direct and supervise a paid worker delivering eligible CHOICES HCBS in the performance of health care task that would otherwise be performed by a licensed nurse. Self-Direction of health care task is not a service, but rather health care-related duties and functions.

ECF CHOICES Consumer Directed HCBS are services that are available only to eligible members enrolled in ECF CHOICES Groups 4, 5, 6 or 7 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only certain ECF CHOICES HCBS are eligible for Consumer Direction. For members in Group 7, Community Transportation is the only eligible HCBS for Consumer Direction.

The Consumer Direction program allows members, or a Member's representative, to direct and manage certain aspects of the provision of such services; primarily, the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s). ECF CHOICES has a modified budget authority and is established based on the Member's needs and the service units necessary to meet the Member's needs.

In Consumer Direction, there are budgets for personal assistance or supportive home care services and a separate budget for community transportation services, which are allocated on a monthly basis. The budget for

respite services are allocated on an annual basis and are disbursed as an hourly respite benefit (up to 216 hours per year). The member may direct each service budget available through Consumer Direction as long as the applicable budget is not exceeded.

A service that is not specified in TennCare rules and regulations as available for Consumer Direction cannot be consumer directed. Participation in Consumer Direction is voluntary; members may elect to participate in or withdraw from Consumer Direction at any time, service by service, without affecting their enrollment in ECF CHOICES.

Consumer Direction is a process by which eligible HCBS are delivered; it is not a service. If a member chooses not to direct his or her care, he or she will receive authorized HCBS through contracted ECF CHOICES providers. Members who participate in Consumer Direction choose either to serve as the employer of record for their workers or to designate a representative to serve as the employer of record on his or her behalf. The member must make arrangements for the provision of needed care and does not have the option of going without needed services.

PROVIDER ROLES, RESPONSIBILITIES AND CREDENTIALING

Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Health care services provided through Amerigroup must be accessible to all members.

Member Care

Amerigroup requires its HCBS providers to have a policy requiring personal care service providers to visually confirm a Member's presence upon arriving to a member's home to deliver services. This will ensure the member is aware of the worker's presence and the worker is aware of the Member's current physical state.

Abuse and Neglect Identification and Reporting

As per Tennessee Code Annotated (TCA) 33-2-402(1):

Abuse: The knowing infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse (of all forms) is a knowing or willful act.

Mental anguish: Significant psychological distress that is intense or persistent and may include fear, anxiety, stress, humiliation, depression, trauma or grief.

In order to be considered mental anguish, the psychological issues experienced must be intense and/or persistent and linked to the actions of the alleged perpetrator. This includes instances of intentional abuse that would result in such mental anguish in a reasonable adult regardless of age or disability.

Physical abuse: Actions including, but not limited to, any physical force, motion or action by which physical harm, pain or mental anguish is inflicted or caused, and/or the use of any unauthorized restrictive or intrusive procedure to control behavior or punish. Corporal punishment, takedowns, prone and supine restraints are prohibited and considered physical abuse.

Sexual abuse: Any type of sexual activity or contact with sexual intent or motivation between a member and a staff person, employee, contracted provider, volunteer or other person interacting with the member (e.g., roommate, acquaintance, caregiver, etc.). This includes but is not limited to actions by which a person is coerced into sexual activity (forced, tricked, induced or threatened) or exposed to sexually explicit material or language. Sexual battery by an authority figure as defined in T.C.A. § 39-13-527 is also considered sexual abuse. Sexual abuse in this situation occurs whether a person is able to give consent to such activities.

Emotional/psychological abuse: A series of repeated incidents, a pattern of behavior or a particularly egregious instance of humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or acts resulting in mental anguish, directed to or within eyesight or audible range of the member. While every instance of such behavior is unacceptable and must be addressed as defined below, not every instance of such behavior rises to the level of emotional or psychological abuse. Emotional/psychological abuse can include an event that negatively affects a person and triggers a behavioral episode that requires intervention by medical personnel, crisis services such as mobile crisis, EMT, ER, and/or law enforcement, etc.

Neglect (TCA 33-2-402[9]): Failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, which results in injury or probable risk of serious harm.

Neglect threshold: In order to be considered neglect, an act or omission of an act must have led to serious injury to the member or another person (i.e., housemate, community member, staff, etc.), or resulted in probable risk that serious injury could have occurred as the result of such action or omission. Probable risk means that it is more likely than not (i.e., a greater than 50 percent chance of occurrence). A serious injury is as defined in *Tier 1 Reportable Events* below.

- Except for extenuating medical circumstances of a member (e.g., a compromised immune system), failure to seek medical attention for a cold or minor illness is not neglect, as there was not probable risk of serious injury.
- Feeding a person with dysphagia whose dietary plan calls for *only* finely ground food a hot dog would constitute neglect, even if the person did not choke, as there was probable risk of serious injury or death from choking.

Misappropriation (TCA 33-2-402[8]): In terms of property, the deliberate misplacement, exploitation or wrongful, temporary or permanent use of belongings or money (i.e., illegally or improperly using a person or person's resources for another's profit or advantage). Misappropriation includes such deliberate action, with or without the consent of a member.

Misappropriation threshold: In order to be considered misappropriation, the property must be valued at more than \$1000 (class E felony).

Quality Monitoring

Amerigroup is responsible for ensuring that each provider within the ECF CHOICES network maintains compliance related to quality of care and service provision. This is accomplished through oversight and monitoring by the Amerigroup Provider Relations and quality teams.

Quality monitoring focuses on the quality of services that go above and beyond the minimum of quality standards. Amerigroup collaborates with the Department of Intellectual and Developmental Disabilities (DIDD) and TennCare for certain ECF CHOICES services, as outlined in the contractor risk agreement and TennCare protocol.

Amerigroup will utilize the information obtained through DIDD Quality Monitoring surveys in determining the appropriate course of action to support and/or counsel each provider in the ECF CHOICES network, but Amerigroup maintains sole responsibility for the quality of providers in the ECF CHOICES network.

The following list outlines ECF CHOICES services and the entities responsible for quality monitoring:

Services monitored by the MCO:

- Assistive technology, adaptive equipment and supplies
- Minor home modifications
- Specialized consultation and training
- Family to family support
- Peer-to-peer self-direction, employment and community support and navigation
- Community support development, organization and navigation

- Decision-making support
- Health insurance counseling/forms assistance

Services monitored by TennCare Audit and Compliance:

- Individual education and training
- Family caregiver stipend
- Family caregiver education and training

Services monitored by DIDD:

- Employment services
- Exploration
- Discovery
- Situational observation and assessment
- Job development plan or self-employment plan
- Job development or self-employment start up
- Job coaching, integrated, competitive employment
- Job coaching, self-employment
- Co-worker supports
- Career advancement
- Supported employment: small group supports
- Integrated employment path services
- Community integration support services
- Independent living skills training
- Personal assistance
- Respite (this service monitored in conjunction with personal assistance and supportive home care; not as a separate service)
- Supportive home care (essential family supports group, only)
- Community transportation (agency-provided only if the provider offers one or more other services monitored by DIDD)
- Community living supports and community living supports: family model

ECF CHOICES Quality Monitoring *Consultative and Annual Survey Process*

The goal of the *Consultative Survey* process is to give providers an opportunity to become familiar with the quality monitoring process and the quality focus areas, outcomes, and indicators on the Quality Monitoring Tool. It is intended to give providers an opportunity to ask questions about the tool and get an understanding of expectations for future surveys.

All ECF CHOICES *Quality Monitoring Surveys* including the initial *Consultative Survey* and subsequent annual surveys are intended to encourage, promote and recognize quality within each ECF CHOICES provider organization. As such, the surveys are expected to be a positive, affirming and constructive experience for providers recognizing what they are doing that signifies quality, encouraging as well as advising them on how to further increase quality practices and outcomes. ECF CHOICES quality monitoring surveyors and provider staff individuals participating in the process are expected to approach the survey experience as an opportunity to work together to recognize and increase quality within each provider organization. The *Quality Monitoring Surveys* are focused on recognizing quality not required, but as a sign of a provider choosing to exceed compliance expectations. TennCare is committed to ensuring that ECF CHOICES quality monitoring processes

maintain these standards and do not promote a “gotcha” or policing culture where the focus is on identifying shortcomings rather than identifying existing strengths and opportunities to build on existing strengths.

The quality monitoring process was designed to measure the quality of ECF CHOICES providers above minimum compliance standards in an effort to recognize high-quality providers and assist providers in working toward continuous quality improvement. A provider interested in achieving the highest level of quality will be expected to effectively demonstrate strong policies and related strategies or procedures that are being appropriately and consistently implemented by all staff for all people receiving ECF CHOICES services with quality outcomes resulting for those served. This should be evidenced by results including quantitative data and qualitative data, such as agency and staff practices, investment of resources, staff attitudes and knowledge, the experience of people receiving services, etc. While all providers must meet minimum compliance standards to maintain status in the network, it is appropriate to expect that few will have reached the highest quality standards at the time of their *Consultative Survey*.

The *Consultative Survey* performance level rating will be determined as follows:

- Best: 76 or higher
- Better than good: 51-75
- Good: 26-50
- Okay: 1-25

Annual survey:

Following the completion of the annual survey, each provider will receive a *Quality Monitoring Survey Report* with narrative feedback, and a performance level rating and preferred provider status.

The annual survey performance level rating will be determined as follows:

- Best: 81 or higher
- Better than good: 61-80
- Good: 31-60
- OK: 1-30

Each performance level rating will correspond with a preferred provider status which is determined as follows:

- Most preferred: 81 or higher
- Highly preferred: 61-80
- Preferred: 31-60
- Not preferred: 1-30

On completion of the *Consultative Survey*, providers will be placed on the annual quality monitoring survey schedule.

Workforce Development

ECF CHOICES providers are responsible for acquiring, developing, and deploying a sufficiently staffed and qualified workforce to capably deliver services to persons supported in a person-centered way. Upon acceptance of an authorization for services, contracted providers shall be obligated to deliver services in accordance with the PCSP, including the amount, frequency, intensity, scope and duration of services specified in the PCSP, and shall be responsible for arranging back-up staff to address instances when other scheduled staff are not able to deliver services as scheduled. The Provider shall, in any and all circumstances, including Provider termination of its Provider Agreement, continue to provide services that maintain continuity of care to the

member in accordance with his/her PCSP until other services are arranged and provided that are of acceptable and appropriate quality.

Service Discontinuation

For service discontinuation:

- Notice is to be provided no less than 60 days prior to the proposed date of service discontinuation in writing to the member (or guardian/conservator) and the Support Coordinator.
- Provider is to obtain written approval/notification from Amerigroup, in the form of a signed PCSP.
- Provider is to cooperate with transition planning, including providing service beyond 60 days if needed and working with the new provider to ensure continuity of care.

ECF CHOICES Provider Business Model

ECF CHOICES HCBS providers are required to maintain written policies and procedures of the provider agency's business model. The policy and procedures shall include at a minimum; roles and responsibilities of key personnel, organizational chart, succession planning, ownership, background checks for all personnel, fraud, waste, and abuse reporting protocols, and a plan for fraud, waste and abuse employee training as required by Deficit Reduction Act of 2005 Section 6032. **A provider's business model of policies and procedures shall include, but is not limited to:**

- Succession planning
- Roles and Responsibilities of key personnel
- Organizational chart
- Ownership
- Background checks
- Fraud, Waste & Abuse reporting protocols
- Prevention of duplicative payments
- Monitoring of missed visits

ECF CHOICES Provider Background Check Requirements

ECF CHOICES providers are required to have policies and processes in place to conduct, in accordance with federal and state law and rule and TennCare policy, criminal background checks on all prospective employees who will deliver CHOICES or ECF CHOICES HCBS, and to document these in the worker's employment record.

This background check must include the following:

- Tennessee Abuse Registry
- Tennessee Felony Offender Registry
- National and Tennessee Sexual Offender Registry
- List of Excluded Individuals/Entities (LEIE & EPLS)

The MCO verifies that any persons required to have background checks, including registry checks, as applicable, who have been employed or have begun volunteering since the last credentialing visit have had criminal background checks, including registry checks, as applicable.

ECF CHOICES providers are required to have a written policy and a process in place to address exception requests for workers who may not initially clear a criminal background check and require a subsequent individualized assessment.

Initial and Ongoing Staff Training Requirements

Providers must have a process in place to provide and document initial and ongoing education to its employees who will provide services to ECF CHOICES members that includes, at a minimum:

- Orientation to the population that staff will support (e.g., elderly, adults with physical disabilities, members with I/DD)
- Disability awareness and cultural competency training including:
 - Person-first language
 - Etiquette when meeting and supporting a person with a disability
 - Working with members who use alternative forms of communication, rely on assistive devices for communication or who may need auxiliary aids or services in order to effectively communicate
- An introduction to behavioral health including:
 - Behavior support challenges that members with I/DD or other cognitive limitations may face
 - Understanding behavior as communication
 - Potential causes of behavior (including physiological or environmental factors)
 - Person-centered supports for members with challenging behaviors (including positive behavior supports)
- The direct support professional's responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions
- Ethics and confidentiality training, including HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act
- Abuse and neglect prevention, identification and reporting
- Reportable event management and reporting
- Documentation of service delivery
- Use of the EVV system
- Delivering person-centered services and supports, including:
 - Federal HCBS setting requirements and the importance of the Member's experience
 - Supporting community integration and participation in the delivery of home and community-based services
 - Facilitating member choice and control
 - Working with family members and/or conservators, while respecting member choice

Required Training for Direct Support Professionals (DSPs)

The requirement topics below are categorized in three ways: 1) The time frame in which the training must be completed; 2) The type/mode of training (external certifications; training modules that are required to be completed online via TennCare/DIDD online training platform with the option to incorporate in-person components; and training modules required to be provided in person by providers' training staff); 3) Training specific to staff providing employment services.

Training required to be conducted in person applies even if the module is based in TennCare/DIDD's online training platform. For example, the provider will be expected to conduct a classroom style presentation of the online training module and incorporate in-person techniques during the module to achieve active engagement and gauge understanding by staff.

Additionally, for all topics except external certifications, demonstration of competency is required regardless of methodology utilized (online vs. in-person). Providers will be required to maintain training completion

documents with attestation of demonstrated competency in the employee's personnel record, signed and dated by the employee and the trainer. These records will be reviewed at least annually.

Trainings Required Prior to Working with a Member

In person using archived, recorded webinar and provider agency-specific presentation *Introduction to ECF CHOICES for Direct Support Professionals*.

- Must be completed in-person using:
 - Archived webinar (25 minutes) available at <https://bcbst.webex.com/bcbst-en/lsr.php?RCID=1d07658bfafd4f4a917bf23b1e49d719>.
 - Presentation by provider agency (minimum 20 minutes) on provider's philosophy, approach and experience (if applicable) in delivering ECF CHOICES services. Ideally should include stories of people served (if applicable) with appropriate consents obtained in advance.
 - At least 15 minutes for Q&A and discussion.
- This training must be the first training module that DSPs complete.
- No exceptions: DSPs who are working in the current DIDD system are still required to complete this module.

Training Modules or In-Person with Demonstrated Competency

Note: These trainings are listed in the recommended order that DSPs should complete them for logical progression of learning.

Disabilities overview

- Completed in TennCare/DIDD 's approved training platform
- Course description: Everyone has a quality they feel sets them apart. Some of us are tall, some short. Some people have blue eyes, others brown. Some differences between people are called disabilities. This course looks closer at what the term disability means and provides an overview of the different types of disabilities you are likely to encounter as a DSP including some of the basic supports people use to further their own independence and participation. Topics include physical and sensory impairments, learning and communication disorders, brain injury and a section on developmental disabilities. Through interactive lessons, as well as descriptive tools and stories, you will learn how to distinguish different types of impairment and disability and become familiar with their causes, characteristics and basic supports appropriate to each. This course is written for DSPs who work in the field of developmental disabilities.
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency signed and dated by the employee and the trainer in the employee's personnel record.

Title VI course

- Completed in TennCare/DIDD 's approved training platform.
- Course description: This course explains the laws and expectations related to nondiscrimination.
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer in the employee's personnel record.

Principles and practices of effective direct supports: the role of the DSP

- Completed in TennCare/DIDD 's approved training platform.

- Course description: This course defines and discusses professionalism as it relates to direct support practice and explains how professionalism is achieved and practiced by people who support people with disabilities. In this course, you will learn time management and organization techniques to benefit the efficiency and effectiveness of your professional practice, as well as investigate the skills, knowledge and attitudes you need to be truly skilled and competent in your important work.
- **Additional requirement:** Providers will need to enhance the modular training to include:
 - Disability awareness and cultural competency training including:
 - Person-first language
 - Etiquette when meeting and supporting a person with a disability
 - Working with members who use alternative forms of communication, such as sign language or nonverbal communication, rely on assistive devices for communication or who may need auxiliary aids or services in order to effectively communicate
 - The DSP's responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer in the employee's personnel record.

HIPAA: Overview

- Completed in TennCare/DIDD 's approved training platform.
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person.
- Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer in the employee's personnel record.

Principles of positive behavior supports for DSPs Part 1: Overview

- Completed in TennCare/DIDD 's approved training platform.
- Course description: In-depth training covering resilience, coping and relationship skills. Behavioral health challenges related to mental health conditions and positive behavior supports are covered. Applied Behavior Analysis (ABA) provided by a behavior analyst is explained, emphasizing the importance of documenting and sharing how the plan is working and/or not working.
- No exceptions: DSPs who are working in the current DIDD system are still required to complete this module.

ECF CHOICES documentation of service delivery

- Completed in TennCare/DIDD 's approved training platform
- Minimum expectations:
 - Goals from PCSP (as related to service)
 - Date/hours worked
 - What did the person do today? (What, where, when, how long, etc.)
 - Who was there? (Name of the supports present, paid staff at a minimum; include natural supports, friends, etc. if applicable)
 - What did you learn that worked well? What did the person like about the activity/opportunity? What needs to stay the same?
 - What did you learn that did not work well? What did the person not like about the activity/opportunity? What needs to be different?

- Other observations from today for the next support person(s).
- No exceptions: DSPs who are working in the current DIDD system are still required to complete this module.

Use of the EVV system *(For PA/SHC/Respite providers only)*

Completed in TennCare/DIDD 's approved training platform

- Note: MCOs may use different EVV systems. DSPs may need to be trained on more than one EVV system.
- No exceptions: DSPs who are working in the current DIDD system are still required to complete this module.

Tennessee DIDD standard precautions

- Completed in TennCare/DIDD 's approved training platform
- Course description: Course covers OSHA universal/standard precautions and the importance of infection control plans maintained by each agency, proper use of personal protective equipment and proper hand-washing.
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer in the employee's personnel record.

Supporting individuals with disabilities during emergencies

- Completed in TennCare/DIDD 's approved training platform.
- Course description: This course provides information for support staff to help members with intellectual or developmental disabilities during emergencies. This course discusses ways to prevent and respond to common emergencies. It discusses safety inside and outside of the home and how to respond to natural disaster emergencies.
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer in the employee's personnel record.

Event Management for Direct Care Professionals platform: video via https://www.youtube.com/watch?v=k_QeSoceq0c

Reportable Event Form Training

- **Completed in** TennCare/DIDD 's approved training platform

Training specific to the person/the person's plan

- Must be completed in person.
- Training must involve more than requiring DSP to read the PCSP and sign off that they have read it. If a *Provider Plan(s) for Service Implementation* has been developed, training should include training on this plan(s) as well as the PCSP.
- No exceptions DSPs who are working in the current DIDD system are still required to complete this module.

External Certifications

- **First aid**
 - Must be completed in person.
 - Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to remain current.
- **CPR with abdominal thrust**
 - Must be completed in person.
 - Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to remain current.
- **As necessary: medication administration**
 - This training is completed in person and is only required if the DSP will administer medications (when employed by a DIDD contracted agency for applicable service).
 - Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to remain current.

Trainings Required Within Thirty Days of Employment

Employment support focused learning

- Completed in TennCare/DIDD 's approved training platform
- Course description: Understanding how to support a member with disabilities to obtain and maintain employment is an essential component of your job as a DSP. In this course you will learn about why employment is important for people with disabilities and how it affects quality of life. You will learn about the types of employment available to people with intellectual and developmental disabilities and the way each of them works. You will be introduced to the individuals of a typical employment team and how they work together to support employment.
- No exceptions: DSPs who are working in the current DIDD system are still required to complete this module.

Supporting reasonable risk-taking necessary for personal growth and dignity

- As of July 12, 2017, in-person training materials are not yet available. Requirement goes into effect when training materials are sent to providers.
- The intent is to load the updated course to TennCare/DIDD 's approved training platform or similar platform in the near future.
- Course description: Supporting persons with I/DD to take planned and reasonable risks necessary for personal growth, living a full life and pursuit/achievement of personal goals.
- No exceptions: DSPs who are working in the current DIDD system are still required to complete this module.

Tennessee conservatorship

- Completed in TennCare/DIDD 's approved training platform
- Course description: An overview of conservatorship in TN. This course will discuss the authority of conservators and the role they play in the lives of members in publicly funded programs. Additionally, this course will discuss alternatives to conservatorship and less restrictive options available to members and their families.
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer in the employee's personnel record.

Trainings Required Within Sixty Days of Employment

People with disabilities: building relationships and community individualship

- Completed in Relias but must also include in-person components.
- In-person content must be developed using: http://www.rtc.umn.edu/docs/Friends_Connecting_people_with_disabilities_and_community_individuals.pdf
- No exceptions: DSPs who are working in the current DIDD system are still required to complete this module.

Person-centered planning for individuals with developmental disabilities

- Completed in TennCare/DIDD 's approved training platform
- Course description: This course is designed to give you the tools you need to incorporate person-centered thinking and planning into your work supporting members with developmental disabilities. In this course, you will learn about what makes person-centered planning different from traditional approaches to developing service plans for members with developmental disabilities. You'll learn about the importance of distinguishing between what is important to a member and what is important for that member, as well as the importance of teamwork in using the person-centered planning approach. Through interactive lessons, personalized planning strategies and descriptive examples, you will learn how to implement the person-centered approach to supporting the members with developmental disabilities with whom you work. This course is appropriate for entry level to intermediate staff and managers.
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer in the employee's personnel record.

Choice making for people with intellectual and developmental disabilities

- Completed in TennCare/DIDD 's approved training platform
- Course description: People with I/DD continue to face barriers to participating as equal individuals of society. They are often seen as unable to make choices or problem-solve in their daily life. As a DSP, you have the opportunity to help teach these skills to the members you serve and help them assert their thoughts, desires and goals. This course provides you with an overview of teaching and supporting the choice-making process for people with I/DD. You will also learn how to empower members to make choices about different techniques for offering choice-making and how to teach problem-solving skills to the people you support. This course is written for DSPs and front-line supervisors who support people with I/DD.
- Exception for DSPs working in the current DIDD system: DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer in the employee's personnel record.

Federal HCBS setting requirements and the importance of the individual's experience

- Completed in TennCare/DIDD 's approved training platform
- Course description: Overview of the HCBS Settings Rule and the impact to service provision for persons supported in publicly funded programs. Review of member rights and requirements related to implementing and documenting restrictions and the fading of restrictions.
- No exceptions: DSPs who are working in the current DIDD system are still required to complete this module.

Job Shadowing Requirements for ECF CHOICES DSPs Providing Services Other than Employment Services

- Job shadowing requirements for employment services are addressed with employment services. If an ECF CHOICES DSP is only providing employment services, the ECF CHOICES DSP only has to complete the shadowing required for employment services.
- Job shadowing for the ECF CHOICES DSP should include a combination of hours addressing the DSP's experience with people who have I/DD, the services the DSP will be providing and the particular member(s) the DSP will be supporting.
- Job shadowing hours shall follow the guidelines below.

Types of Job Shadowing

- Realistic job preview: Within the first week of hire, DSPs new to working with people with I/DD should shadow to obtain a realistic job preview: 2-4 hours; minimum 2 hours.
- Type of service: The DSP new to providing ECF CHOICES services should shadow in each type of service(s) they will provide: 4-8 hours per service type; minimum 4 hours per service type.
- Specific to the member: The DSP should job shadow based on the member(s) they will begin supporting: 2-4 hours; minimum 2 hours.

DSP Categories (based on experience)

- New DSP (no experience with people with I/DD or ECF CHOICES services): Needs to complete all three types of job shadowing listed above.
- New to ECF CHOICES service: Has experience with people with I/DD but no ECF CHOICES services experience: Needs to complete the second and third types of job shadowing listed above.
- DSP experience as ECF CHOICES service provider: Has experience working with people with I/DD in ECF CHOICES services but no experience specific to the member(s) to be supported: Needs to complete the third type of job shadowing listed above.

Job Shadowing Expectations

- Ideally, to reduce the amount of job shadowing an ECF CHOICES DSP needs to complete, the shadowing should be with an experienced ECF CHOICES DSP (or DSP supervisor trained as an ECF CHOICES DSP) serving the specific member(s) to be supported in the type of ECF CHOICES service(s) that the new DSP will be providing to that member. For example, if a new DSP shadows for four hours in the service type they will be providing and with the member(s) they will be supporting, this time can count toward meeting the above requirements for both shadowing for type of service and shadowing specific to the member.
- If the member(s) to be supported is newly enrolled or new to the provider, the shadowing should be with an experienced DSP (or DSP supervisor trained as an ECF CHOICES DSP) serving an ECF CHOICES member with similar support needs in the type of service(s) the new DSP will be providing.
- If the member with similar support needs is not being served by the provider, the shadowing will be with an experienced DSP (or DSP supervisor trained as an ECF CHOICES DSP) in the type of service(s) the new DSP will be providing.
- Job shadowing should include shadowing the delivery of all types of ECF CHOICES services (nonemployment) that the DSP will be assigned to provide.
- If the agency is beginning the provision of a new ECF CHOICES service and does not have an experienced DSP, the agency is expected to use a DSP supervisor who is trained on the ECF CHOICES service(s) to accompany the DSP to begin the ECF CHOICES service(s) with the member thereby allowing the new DSP to shadow the DSP supervisor who will model quality service provision and support.

Additional/enhanced training is required for DSPs providing ECF CLS — behavioral health stabilization and transition (CLS — BHCST) services and behavior support specialists (BSS) providing services to members in ECF Groups 7 and 8.

Note: The above is for all nonemployment **and** employment providers. Employment provider staff persons are required to complete additional, employment specific trainings. These specific trainings are identified in the following section.

Staff Qualifications for Employment Providers

Supported Employment: Individual Employment Support

- Exploration
- Benefits counseling
- Discovery
- Situational observation and assessment
- Job development plan or self-employment plan
- Job development or self-employment start-up
- Job coaching
 - Job coaching for individualized, integrated employment
 - Job coaching for individualized, integrated self-employment
- Co-worker supports
- Career advancement
- Supported Employment: Small Group Supports
- Integrated employment path services

There are core qualifications that all staff providing ECF CHOICES employment services must meet. There are additional requirements for training and/or certification depending on whether staff is serving in the capacity of job coach, job developer, certified benefits counselor or supported employment supervisor/manager. These requirements have been specifically defined to best position ECF CHOICES employment services providers to support members with I/DD enrolled in the program with achieving their employment goals.

Any staff providing ECF CHOICES employment services must meet the following qualifications:

- 18 years of age or older
- Effectively read, write and communicate verbally in English, and in the person's first language if not English and the person is not fluent in English
- Able to read and understand instructions, perform record-keeping and write reports
- GED or high school diploma
- Pass criminal background checks as required by TennCare for the ECF CHOICES program and not be listed on the Tennessee Department of Health Abuse Registry or Tennessee Sexual Offender Registry
- If driving is involved in job duties, valid driver's license and automobile liability insurance
 - If using own vehicle to transport members, appropriate insurance coverage for this purpose
(Note: The provider agency may contribute towards the cost of appropriate insurance coverage to transport members)
- Completion of required training for all DSPs working in the ECF CHOICES program
- Information/training specific to person(s) being served

While not required, it is preferred that all staff providing ECF CHOICES employment services have a minimum of six months' experience working with members with ID and/or DD, where the work included teaching skills and/or tasks, preferably in an employment setting.

Specific Requirements

There are specific qualifications required for staff to provide ECF CHOICES Employment Services, depending on whether the staff are serving in the capacity of Job Coach, Job Developer, Certified Benefits Counselor or Supported Employment Supervisor/Manager.

For each ECF CHOICES Employment Service, TennCare has established the type of staff that is required to provide the service. See table below, specifically the column titled **Required Job Type**. The corresponding qualifications for each type of staff are in column three of the table below.

There will be no grandfathering (waiving of ECF CHOICES qualifications) for staff qualified to provide employment services under DIDD waivers or Vocational Rehabilitation (VR). All staff providing employment services in ECF CHOICES need to comply with the staff qualifications set forth in this document. However, providers that are credentialed to provide ECF CHOICES employment services and, at the time of credentialing, have existing employment service staff otherwise qualified to provide employment services under DIDD waivers and/or VR, will have a one-year grace period, from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services, to ensure these existing staff obtain the required ECF CHOICES qualifications they may not currently hold.

The below table summarizes what the minimum staff qualifications are for ECF CHOICES employment services, and the associated trainings and/or certificates required, including the supported employment manager/supervisor, although there isn't a specific service that corresponds with this position.

Employment services	Required job type	Minimum staff qualifications/training	Time frame for meeting minimum qualifications/successfully completing training
<ul style="list-style-type: none"> • Exploration • Situational observation and assessment • Job coaching: individual wage employment • Supported employment • Integrated employment path services 	Job coach	<p>Meets job developer qualifications/training requirements (i.e., holds CESP or ACRE certification)</p> <p>OR</p> <ul style="list-style-type: none"> • Training Resource Network, Inc. (TRN) job coaching and consulting: design, training and natural support online web course <p>PLUS</p> <p>Shadowing of existing trained/qualified job coach (or a job coach trained/qualified under the Department of Intellectual and Developmental Disabilities (DIDD) waivers or Vocational Rehabilitation (VR), if no ECF CHOICES job coach is in place in the local area) for at least four hours in at least three different job coaching situations/work sites (equates to a total of 12 hours of shadowing).</p>	<p>For existing staff (in place as of the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services) who are qualified as a job coach under the Department of Intellectual and Developmental Disabilities (DIDD) waivers or a (VR) Letter of Agreement (LOA), there is a one year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services.</p> <p>For new hires, the qualifications must be met prior to providing ECF CHOICES services.</p>

Employment services	Required job type	Minimum staff qualifications/training	Time frame for meeting minimum qualifications/successfully completing training
Benefits counseling	Certified work incentives counselor (CWIC) or CWIC community partner	Level 5 suitability clearance AND CWIC certification through Virginia Commonwealth University (VCU) or Cornell AND Ongoing continuing education requirements to maintain CWIC certification	The qualifications must be met prior to providing the ECF CHOICES benefits counseling service.
<ul style="list-style-type: none"> • Discovery • Job development plan • Job development • Career advancement 	Job developer	<p>Association of People Supporting Employment (APSE) certified employment support professional (CESP) certificate received through passing an exam</p> <p>OR</p> <p>ACRE basic employment certificate – the supported employment online certificate series earned through Virginia Commonwealth University</p> <p>OR</p> <p>ACRE basic employment certificate in community employment with emphasis on customized employment offered by Griffin-Hammis Associates</p> <p>OR</p> <p>ACRE basic employment certificate – college of employment services (CES) plus offered by University of Massachusetts Institute for Community Inclusion</p> <p>OR</p> <p>ACRE national certificate of achievement in employment services earned through University of Tennessee (UT)</p> <p>OR</p> <p>ACRE professional employment certificate earned through completion of “Work Works” online course offered by University of Georgia Institute on Human Development and Disability</p>	<p>For existing staff (in place as of the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services) who are qualified as a job developer (employment specialist) under a VR LOA, there is a one year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services.</p> <p>For new hires qualifying as a job developer through the CESP, the CESP qualification must be obtained prior to providing ECF CHOICES services.</p> <ul style="list-style-type: none"> • For new hires qualifying as a job developer through ACRE certification, the first four (4) weeks of the ACRE course must be completed prior to providing ECF CHOICES services AND the entire ACRE course must be successfully completed (certification obtained and copy provided to each MCO) in order to continue to provide ECF CHOICES services. Additionally, all work done with ECF CHOICES members prior to the successful completion of the entire ACRE course must be monitored, with written products reviewed and approved via co-signature, by a qualified job developer (employment specialist) or supported employment program manager.

Employment services	Required job type	Minimum staff qualifications/training	Time frame for meeting minimum qualifications/successfully completing training
<ul style="list-style-type: none"> • Self-employment plan • Self-employment start-up 	Job developer	<ul style="list-style-type: none"> • Any of the qualifications/trainings listed in the row above <p>AND</p> <p>TennCare/DIDD 's approved training platform ten modules on customized self-employment developed by Griffin-Hammis Associates</p>	<p>For existing staff (in place as of the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services) who are qualified as a job developer (employment specialist) under a VR LOA, there is a one year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services.</p> <p>For new hires, qualifying as a job developer through the CESP, the CESP qualification must be obtained prior to providing ECF CHOICES services.</p> <ul style="list-style-type: none"> • For new hires qualifying as a job developer through ACRE certification, the first four (4) weeks of the ACRE course must be completed prior to providing ECF CHOICES services AND the entire ACRE course must be successfully completed (certification obtained and copy provided to each MCO) in order to continue to provide ECF CHOICES services. Additionally, all work done with ECF CHOICES members prior to the successful completion of the entire ACRE course must be monitored, with written products reviewed and approved via co-signature, by a qualified job developer (employment specialist) or supported employment program manager.

Employment services	Required job type	Minimum staff qualifications/training	Time frame for meeting minimum qualifications/successfully completing training
Job coaching self-employment	Job coach	<p>Meets job developer qualifications/training requirements (i.e., holds CESP or ACRE certification)</p> <p>PLUS</p> <ul style="list-style-type: none"> TennCare/DIDD 's approved training platform ten modules on customized self-employment developed by Griffin-Hammis Associates <p>OR</p> <ul style="list-style-type: none"> TRN job coaching and consulting: design, training and natural support online web course <p>AND</p> <p>Shadowing of existing trained/qualified ECF CHOICES job coach (or a job coach trained/qualified under DIDD Waiver/VR if no ECF CHOICES job coach is in place in the local area) for at least four hours in at least three different job coaching situations/work sites (equates to a total of 12 hours of shadowing)</p> <p>PLUS</p> <p>TennCare/DIDD 's approved training platform ten modules on customized self-employment developed by Griffin-Hammis Associates</p>	<p>For existing staff (in place as of the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services) who are qualified as a job coach under the Department of Intellectual and Developmental Disabilities (DIDD) waivers or a VR LOA, there is a one year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services.</p> <p>For new hires, the qualifications must be met prior to providing ECF CHOICES services.</p>
Not applicable (there is no specific service that corresponds with this position)	Supported Employment Program manager/supervisor of job coaches and job developers	<p>ACRE professional employment certificate earned through completion of "Work Works" online course offered by University of Georgia Institute on Human Development and Disability</p> <p>OR</p> <p>Certified rehabilitation counselor (CRC status) and meeting continuing education requirements to maintain the CRC designation</p> <p>OR</p> <p>ACRE professional employment certificate (UT)</p>	<p>For existing program managers/supervisors (in place as of the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services), there is a one year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services.</p> <p>For new hires, the qualifications must be met within six months of hire.</p>

Home- and Community-Based Services Settings Rule Compliance

Home- and community-based services (HCBS)

- Are integrated in and support access to the greater community.

- Provide opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources.
- Ensure the person receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
- Are selected by the person from among setting options including nondisability-specific settings and an option for a private unit in a residential setting.

The intent of the HCBS Final Rule is to ensure that members receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and an opportunity to receive services in the most integrated setting appropriate, enhance the quality of HCBS and provide protections to participants.

During the credentialing process and prior to Amerigroup executing a provider agreement with a provider seeking Medicaid reimbursement for ECF CHOICES, Amerigroup is required to verify that the provider is compliant with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5). Providers are required to indicate their level of compliance with the HCBS Settings Rule by completing a provider self-assessment issued by Amerigroup. When a provider has returned their self-assessment indicating their full compliance with the HCBS Settings Rule, Amerigroup will verify provider compliance during the credentialing process prior to executing an agreement with a provider and during recredentialing. If a provider is not compliant with the HCBS Settings Rule, Amerigroup cannot contract with the provider. If at any time a previously compliant provider is deemed to be out of compliance with the HCBS Settings Rule, Amerigroup will require the provider to complete a corrective action plan detailing action steps and timelines to remedy any noncompliance. If a provider does not follow the corrective action plan or if the provider determines they are unwilling/unable to continue compliance with the HCBS Settings Rule, the provider will be terminated from the ECF CHOICES network and any currently served members receiving HCBS will be transferred to a compliant provider.

Amerigroup uses our HCBS settings audit tool to verify compliance with the Settings Rule. Amerigroup will complete annual HCBS settings audits that include evaluating physical location, policies, procedures and other written documentation, employee training and sampling employee files. In addition, in accordance with the *Contractor Risk Agreement*, we will conduct ongoing provider education training and technical assistance on the HCBS Settings Rule, as deemed necessary by TennCare.

The Amerigroup Settings Compliance Committee for ECF CHOICES will review referrals provided from the support coordinators/care coordinator leadership and as part of their review they should complete the following:

- Review any proposed or emergency right restrictions and restraints included and not included in a BSP, PCSP or plan of care for potential human rights violations. Ensure informed consent for any restrictions.
- Provide input for any modifications to members' rights when the member resides in a provider owned or controlled residential setting prior to modification being included in a Member's PCSP.
- Review potential violations to HCBS Settings Rules in instances in which a member is living in an unlicensed setting or licensed setting other than those covered in benefits for ECF CHOICES members that may be in violation of HCBS Settings Rules. Make recommendations for becoming compliant with HCBS Settings Rules.
- Review of the number of psychotropic medications prescribed including the use of PRN psychotropic medication.
- Review and make recommendations regarding complaints received pertaining to potential human rights violations.

- Ensure proposed restrictions are the least restrictive viable alternative and are not excessive.
- Ensure proposed restrictions are not for staff convenience.

BILLING AND CLAIMS SUBMISSION

Cost-Sharing and Patient Liability

Providers shall not require any cost-sharing or patient liability responsibilities for covered services, except to the extent that cost-sharing or patient liability responsibilities are required for those services by TennCare rules and regulations, including holding members liable for debt due to insolvency of Amerigroup or nonpayment by the state to Amerigroup. Further, providers shall not charge members for missed appointments.

Patient Liability

TennCare will notify Amerigroup of any applicable patient liability amounts for ECF CHOICES members via the eligibility/enrollment file. Members owing patient liability will pay that amount to Amerigroup.

Preventive Services

TennCare cost-sharing or patient liability responsibilities apply to covered services other than the preventive services described in TennCare rules and regulations.

Provider Requirements

Providers or collection agencies acting on the provider's behalf may not bill members for amounts other than applicable TennCare cost-sharing or patient liability amounts for covered services, including services that the state or Amerigroup has not paid for, except as permitted by TennCare rules and regulations and as described below.

Providers may seek payment from an enrollee only in the following situations:

- If the services are not covered services and, prior to providing the services, the provider informed the member that the services were not covered
 - The provider will inform the enrollee of the noncovered service and have the enrollee acknowledge the information. If the member still requests the service, the provider will obtain such acknowledgment in writing prior to rendering the service; regardless of any understanding worked out between the provider and the member about private payment. Once the provider bills Amerigroup for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the member.
- If the Member's TennCare eligibility is pending at the time services are provided and if the provider informs the person, he or she will not accept TennCare assignment whether or not eligibility is established retroactively
 - Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Amerigroup for the service, the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.
- If the Member's TennCare eligibility is pending at the time services are provided; however, all monies are collected, except applicable TennCare cost-sharing or patient liability amounts, shall be refunded when a claim is submitted to Amerigroup because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established
 - The monies collected will be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim.
- If the services are not covered because they are in excess of an enrollee's benefit limit, and the provider complies with applicable TennCare rules and regulations.

Providers must accept the amount paid by Amerigroup or appropriate denial made by Amerigroup (or, if applicable, payment by Amerigroup that is supplementary to the Individual's third-party payer) plus any applicable amount of TennCare cost-sharing or patient liability responsibilities due from the member as payment in full for the service. Except in the circumstances described above, if Amerigroup is aware that a provider or a collection agency acting on the provider's behalf bills a member for amounts other than the applicable amount of TennCare cost-sharing or patient liability responsibilities due from the enrollee, we will notify the provider and demand that the provider and/or collection agency cease such action against the member immediately. If a provider continues to bill a member after notification by Amerigroup, we will refer the provider to the Tennessee Bureau of Investigation.

Disclosure Reporting

Providers, whether contract or non-contract, shall comply with all federal requirements (*42 CFR Part 455*) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in *42 CFR Part 455, Subpart B* and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request. For providers, this requirement may be satisfied through TENNCARE's provider registration process.

Authorization/Notification Requirements

Authorization is required for all ECF CHOICES services. Prior to rendering services, providers will receive an authorization or preauthorization communicating approval to provide the service.

To request an LTSS authorization or a change in the Member's PCSP, please send an email to ltcprovreq@amerigroup.com and include the following information:

- Provider name and Amerigroup provider ID
- Member's name/Amerigroup subscriber ID
- Dates of service/ service type/unit amount requested
- Schedule requested by the member (for services monitored through the EVV system)

These requests will be sent to the Member's support coordinator, who will take action and determine if such authorization or change request is appropriate for the member. If approved, an authorization will be sent to you via DocuSign*, typically within two business days of the initial request. In order to update their contact information to receive information via DocuSign, providers should email ltcprovreq@amerigroup.com. It is the provider's responsibility to communicate acceptance of an authorization. Failure to accept an authorization will result in the authorization being offered to another provider. Please also ensure accurate contact numbers are provided to Amerigroup to ensure proper communication is possible. To maintain current records, please provide the email address (es) you wish to have on file with Amerigroup to ltcprovreq@amerigroup.com.

Providers shall notify Amerigroup in writing at least sixty (60) days prior to the date of the proposed termination of services for a member.

Electronic Submission

Amerigroup encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 120 days from the date of discharge for inpatient services, or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation, or in cases where a member has retroactive eligibility.

For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from TennCare of the Member's eligibility/enrollment.

Effective January 1, 2019, Availity* is our designated Electronic Data Interchange (EDI) gateway and E-Solutions Service Desk. How to register with Availity:

- If you wish to submit directly, you can connect to the Availity EDI Gateway at no cost for you go to <https://www.availity.com> and select **Register**. If you have any questions or concerns, please contact Availity at **1-800-AVAILITY (1-800-282-4548)**.
- Availity — Payer ID 26375; Phone: **1-800-282-4548**

Providers have the option of submitting claims electronically through EDI. The advantages of electronic claims submission include:

- Facilitating timely claims adjudication
- Acknowledging receipt and rejection notification of claims electronically
- Improving claims tracking
- Improving claims status reporting
- Reducing adjudication turnaround
- Eliminating paper
- Improving cost-effectiveness
- Allowing for automatic adjudication of claims

Registering with Availity

If you choose to submit directly through Availity but are not yet a registered user, go to <https://www.availity.com> and select **Register**.

The registration wizard will lead you through the enrollment process. Once complete, you will receive an email with your login credentials and next steps for getting started. If you have any questions or concerns, please contact Availity at **1-800-AVAILITY (1-800-282-4548)**.

It is our priority to deliver a smooth transition to Availity for our EDI services. If you have questions, please contact your Provider Relations representative or Provider Services at **800-454-3730**.

ECF Claiming in CareBridge

Effective April 1, 2021, ECF CHOICES providers are able to submit claiming for all ECF CHOICES services through CareBridge, in addition to Availity. The advantages of utilizing CareBridge include,

- Real-time Reporting
- Access to Authorizations

- Streamline Billing

Effective June 1, 2021, ECF CHOICES providers are required to submit the following outcome-based employment services via the CareBridge system. This includes submitting all outcome-based reports.

- Exploration - Individual
- Benefits Counseling
- Discovery - Individual
- Situational Observation and Assessment - Individual
- Job Development Plan
- Self-Employment Plan
- Job Development Start Up
- Self-Employment Start Up
- Career Advancement
- Transition from small group to individual employment – Note, this is an Incentive Payment, not a 'service'

Electronic Visit Verification System

Select HCBS providers must submit claims through the Electronic Visit Verification (EVV) system (see the [Electronic Visit Verification System](#) section for more details).

Website Submission

Participating providers have the option to utilize the claim submission utilities available on the Amerigroup provider website. Providers will have the ability to enter claims on a preformatted CMS1500 and/or UB-04 claim template. Provider offices and facilities that are able to create HIPAA compliant ANSI 837 4010A1 claim transactions will have the ability to upload the claims on the provider website. In order to take advantage of the direct submission of ANSI 837 claim files, please contact the EDI Hotline at 1-800-590-5745.

Paper Claims Submission

Providers also have the option of submitting paper claims. All claims should be submitted on original red claim forms (not black and white or photocopied forms), and laser printed or typed (not handwritten) in a large, dark font. A corrected claim via UB-04 CMS-1450 or CMS-1500 (08-05) must be submitted within 120 days from the date of discharge for inpatient services, or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility.

For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from TennCare of the Member's eligibility/enrollment.

CMS-1500 (08-05) and UB-04 CMS-1450 must include the following information (HIPAA compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- Patient's account number
- ICD-10 diagnosis code/revenue codes
- Date of service

- Place of service
- Procedures, services or supplies rendered
- CPT-4 codes, HCPCS codes and diagnosis-related groups, with appropriate modifiers if necessary
- National drug codes (NDCs)
- Present on admission (POA) indicators
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- NPI of billing and rendering provider, when applicable
- Coordination of benefits/other insurance information
- Authorization/precertification number or a copy of the authorization/precertification
- Name of referring physician
- NPI of referring physician, when applicable
- Any other state required data

For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from TennCare of the Member's eligibility/enrollment. Paper claims must be submitted to the following address:

Amerigroup Tennessee Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

International Classification of Diseases, 10th Revision (ICD-10) Description

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements, and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9) which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- Clinical modification (CM): used for diagnosis coding
- Procedure coding system (PCS): used for inpatient hospital procedure coding (this is a variation from the WHO baseline and unique to the United States)

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

Claims Adjudication

Amerigroup is dedicated to providing timely adjudication of provider claims for services rendered. All network and non-network provider claims that are submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Hospital facility claims should be submitted using UB-04 CMS-1450 and provider services should be submitted using CMS-1500.

Providers must use HIPAA compliant billing codes when billing Amerigroup. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Amerigroup will not pay any claims submitted using noncompliant billing codes.

Amerigroup reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within 120 days from the date the service is rendered, or for inpatient claims filed by a hospital, within 120 days from the date of discharge.
- In the case of other insurance, submit the claim within 120 days of receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 120 days from the date the eligibility is added, and Amerigroup is notified of the eligibility/enrollment.
- Claims submitted after the 120-day filing deadline will be denied.
- Corrected claims or replacement claims may be submitted within 120 calendar days of Amerigroup payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

After filing a claim with Amerigroup, review your weekly EOP. If the claim does not appear on an EOP within 14 calendar days as adjudicated, or you have no other written indication that the claim has been received, check the status of your claim on our website at <https://providers.amerigroup.com/TN>, or the telephonic Provider Inquiry Line at **866-840-4991**. If the claim is not on file with Amerigroup, resubmit your claim within 120 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from EDI or your practice management vendor.

Clean Claims Adjudication

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted by a provider in a timely manner
- Is accurate
- Is submitted on a HIPAA compliant standard claim form, including a CMS-1500 (08-05), UB-04 CMS-1450, successor forms thereto or the electronic equivalent of such claim form
- Is a complete claims submission following any and all HIPAA compliance standards (Levels 1-7)
- Includes an NPI and taxonomy information for rendering, attending and billing providers
- Requires no further information, adjustment or alteration by a provider in order to be processed and paid by Amerigroup
- Includes, for all J-codes billed, required NDC code and drug pricing information (NDC quantity, unit price and unit of measurement); exceptions are:

- Vaccines for children, which are paid as an administrative fee
- Inpatient-administered drugs
- Radiopharmaceuticals, unless the drug is billed separately from the procedure

Ninety percent of clean claims are adjudicated within 14 calendar days and 99.5 percent within 21 calendar days of receipt of a clean claim.

Claims submitted on paper and determined to be unclean will be returned to the billing provider along with a letter stating the reason for rejection. For electronic claims (EDI), claims that are determined to be unclean will be returned to an Amerigroup contracted clearinghouse (Availity), and in turn will be reported out to either the billing provider or the vendor the billing provider used to submit the claim.

Amerigroup produces and mails an EOP to providers on a biweekly basis, which delineates the status of each claim that has been adjudicated during the previous claim cycle.

Claims Status

Providers should use our provider website at <https://providers.amerigroup.com/TN> or call the automated Provider Inquiry Line at **866-840-4991** to check claims status. For information on accepted and rejected claims submitted electronically, providers should also use the claims status information available through the Availity clearinghouse.

Provider Claim Payment Disputes and Independent Review

For information on provider payment disputes and independent reviews, please refer to the general Amerigroup provider manual found at <https://providers.amerigroup.com/TN>.

MARKETING

ECF CHOICES/Money Follows the Person Materials and Logos

Providers are prohibited from altering, in any manner, ECF CHOICES or Money Follows the Person (MFP) materials, unless Amerigroup has submitted a request to do so to TennCare and obtained prior written approval from TennCare.

Providers are prohibited from reproducing, for their own use, the ECF CHOICES or MFP logos unless Amerigroup has submitted a request to do so to TennCare and obtained prior written approval from TennCare.

Disclaimers will appear on back cover:

- * CareBridge is an Electronic Visit Verification (EVV) vendor providing an electronic system used to monitor a Member's receipt and utilization of certain services for Amerigroup Community Care.
- * Relias is an electronic healthcare data platform providing training and education on behalf of Amerigroup Community Care. Amerigroup will implement training based on TennCare/DIDD 's approved training platform.
- * DocuSign is an electronic document management platform providing a secure electronic signature process on behalf of Amerigroup Community Care.
- * Availity is an independent company that administers the secure provider portal on behalf of Amerigroup Community Care.

1915(c) WAIVER PROGRAMS

INTRODUCTION

The 1915(c) Waiver includes three waivers (Statewide, Comprehensive Aggregate Cap, and Self-Determination) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which provides HCBS not otherwise available under the State Plan to eligible persons with I/DD enrolled in such waivers. The definitions for the three waivers are outlined below.

Statewide Home and Community Based Services (HCBS) Waiver - A HCBS Waiver (Control Number TN 0128) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves children and adults with intellectual disabilities and children under age six with a developmental disability who qualify for and, absent the provision of services provided under the Statewide Waiver, would require placement in a private Intermediate Care Facility for Members with Intellectual Disabilities (ICF/IID). The Statewide Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participant's Person-Centered Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Comprehensive Aggregate Cap (CAC) Home and Community Based Services (HCBS) Waiver – A HCBS Waiver (Control Number TN 0357) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves members with intellectual disabilities who are former members of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), former members of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), persons discharged from the Harold Jordan Center following a stay of at least 90 days, and members transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver. These are members who have been institutionalized in a public institution, were part of a certified class because they were determined to be at risk of placement in a public institution, or have significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an Intermediate Care Facility for Members with Intellectual Disabilities (ICF/IID). The CAC Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participant's Person-Centered Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

1. The CAC Waiver serves people who: 1) received services in a public Intermediate Care Facility for Members with Intellectual Disabilities ("ICF/IID"); 2) are part of a certified class because they were determined to be at risk of placement in a public ICF/IID; 3) significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an ICF/IID. Entry into this waiver is closed to enrollment other than those meeting all of the following criteria: Meet TennCare ICF/IID level of care criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a Pre-Admission Evaluation ("PAE") approved by TennCare.
2. Have been assessed and found to have an intellectual disability manifested before eighteen (18) years of age, as specified in Tennessee State law (T.C. A. §§ 33-1-101).

3. A person discharged from the Harold Jordan Center (HJC) following a stay of at least ninety (90) days, or a member transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, or January 1, 2020, because he or she was identified by the State as receiving services in excess of the individual expenditure cap established for the Statewide Waiver.

Note: Former class members may no longer enroll in the CAC Waiver, unless all of the criteria listed above are met.

Self-Determination Waiver Program- A Home and Community Based Services (HCBS) Waiver (Control Number TN 0427) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves children and adults with intellectual disabilities and children under age six with developmental delay who qualify for and, absent the provision of services provided under the Self-Determination waiver, would require placement in a private Intermediate Care Facility for Members with Intellectual Disabilities (ICF/IID). The Self-Determination Waiver Program affords persons supported the opportunity to directly manage selected services, including the recruitment and management of service providers. Participants and families (as appropriate) electing self-direction are empowered and have the responsibility for managing, in accordance with waiver service definitions and limitations, a self-determination budget affording flexibility in service design and delivery. The Self-Determination Waiver Program serves persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home and whose needs can be met effectively by the combination of waiver services through this program and natural and other supports available to them. The Self-Determination Waiver does not include residential services such as supported living. The Self-Determination Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participant's Person-Centered Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

CONTACT INFORMATION

TennCare and the Department of Intellectual and Development Disabilities (DIDD) have created several protocols that guide the provision of services across the IDD MLTSS system. You may view all these protocols on TennCare's website: <https://www.tn.gov/tenncare/long-term-services-supports/partners-program-updates/ltss-protocols.html>

The following list of protocols can be found on the TennCare LTSS Protocol Webpage:

- LTSS Protocol for Consumer Direction Cost in the 1915(c) Waivers
- Dental Benefit Management Protocol
- Community Informed Choice for ICF/IID Admissions
- Employment Informed Choice Protocol
- Enabling Technology Protocol
- Behavior Services and Associated Supports for MCO Members Receiving 1915(c) Waiver Services
- Therapeutic Services for MCO Members Receiving 1915(c) Waiver Services
- Self-Direction of Health Care Tasks
- Coordination of Benefits for MCO Members Receiving 1915(c) Waiver Services
- Credentialing Standards Protocol

For 1915(c) Waiver providers, please email the Department of Intellectual and Developmental Disabilities (DIDD) at DIDD_Billing.ACR@tn.gov for all claims related inquiries.

Appeals and Grievances will be completed per the instructions noted in the Member's appeal letter.

Providers are able to access policies and procedures regarding authorization of service at <https://www.tn.gov/content/dam/tn/didd/documents/policies/80/80.3.4%20-%20Authorization%20of%20Services.pdf>.

Additional information regarding contracting, credentialing and payment of claims can be found throughout this supplemental manual.

Members enrolled in the 1915(c) Waiver Program can call DIDD's Member Services at: West TN Regional Office **866-372-5709**; Middle TN Regional Office 1-800-654-4839; East TN Regional Office **888-531-9876** to speak to someone about their benefits. Members can also contact the 24-hour Amerigroup Nurse HelpLine for:

- Around-the-clock clinical services.
- Assistance with coordinating behavioral health care needs.

DIDD Customer-Focused Service is a streamlined single-entry point for advocacy, complaint resolution, conflict resolution and mediation for persons supported in the 1915(c) waiver.

- Customer-Focused Service is committed to assisting members, family members and providers to ensure their concerns are heard and addressed with focus on the person's rights and with respect to their dignity of choice

Customer-Focused Service Coordinators collaborate on behalf of the member, DIDD representatives and all stakeholders, to address issues and find solutions. The Customer-Focused Service unit does not conduct investigations or address provider or staff conflict which does not relate to a member. Customer-Focused Service refers allegations of abuse, neglect, or exploitation to DIDD Investigations Unit.

Please submit correspondence to Customer-Focused Service at DIDD.CustomerFocusedService@tn.gov or call toll free via **833-696-2089**.

After business hours, please leave a message and one of the CFS staff will return your call the next business day.

Your Customer-Focused Service Coordinators are:

- West: Yolanda Beason and Rhonda Alston
- Middle: Sherry Baskerville and Schavonne Hallmon
- East: Dr. Mike Mailahn and Jerry Winters

The following are additional Amerigroup resources you may find useful:

- Provider Services fax: **800-964-3627**
- Provider Relations: **800-454-3730**
- Behavioral Health inpatient authorizations: Should be submitted electronically using our preferred method at <https://provider.amerigroup.com/TN>. If you prefer to paper fax, forms are located on the same provider website.
- Behavioral Health outpatient services fax: **866-920-6006**
- Electronic Data Interchange (EDI) Hotline: **800-590-5745**
- Electronic Visit Verification (EVV) Help Desk: **855-329-2116**
- Family Assistance Service Center: **615-743-2000**
- Fraud and Abuse Hotline: **800-433-3982**

MEMBER ELIGIBILITY AND ENROLLMENT

The Statewide Waiver, CAC Waiver and Self-Determination Waiver are closed to new referrals. Any member receiving services through the Self-Determination Waiver that requires support beyond what that waiver offers may be referred to the ECF CHOICES program.

Tennessee Family Support Program

The primary focus of the Family Support Program¹ (as outlined in T.C.A. §§ 33-5-203) is supporting: 1) families with children with a severe or developmental disability, school age and younger; 2) adults with a severe or developmental disability who choose to live with their families; and 3) adults with a severe or developmental disability who are residing in the community in an unsupported setting (not a state- or federally funded program). For more information on eligibility criteria for enrollment see the Family Support Program guidelines, which are available online on DIDD website, <https://www.tn.gov/didd/consumers/family-support-program.html>.

¹ The Family Support Program is a coordinated system of family support services administered by DIDD directly or through contracts with providers of those family support services and which is funded wholly by the State of Tennessee, pursuant to T.C.A. § 33-5-201, et al.

MEMBER BENEFIT AND SUPPORTS

The following long-term services and supports are available to 1915(c) waiver members, per waiver program and subject to all applicable service definitions, benefit limits, and Expenditure Caps, when the services have been determined medically necessary by the contractor.

Benefit	Self-Determination	Statewide	CAC
Support Coordination (limited to 1 unit per month)		X	X
Transitional Case Management(limited to the last 180 consecutive days of the Individual’s institutional stay prior to being discharged and enrolled in the waiver)		X	X
Personal Assistance (limited to a maximum of 215 hours per month; out of state PA has same limits, and in addition-limited to a maximum of 14 days per calendar year)	X	X	X
Enabling Technology (limited to a maximum of \$10,000 per member per two calendar years, including SMESAT)	X	X	X
Specialized Medical Equipment/Supplies and Assistive Technology (limited to a maximum of \$10,000 per member per two calendar years, including ET)	X	X	X
Personal Emergency Response Systems (monitoring limited to 1 unit per month/12 units per calendar year)	X	X	X
Environmental Accessibility Modifications (limited to a maximum of \$15,000 per person for 3 consecutive calendar years)	X	X	X
Supported Employment – Individual(Exploration-limited to 1 unit per 365 days; Discovery-limited to 1 unit per day per 1,095 days; Job Development-limited to 1 unit per 365 days; Stabilization and Monitoring-limited to 1 unit per month; all employment/day services combined are limited to a maximum of 240 units per a 14-consecutive-day billing period and 5,832 units per calendar year)	X	X	X

Benefit	Self-Determination	Statewide	CAC
Supported Employment – Small Group (all employment/day services combined are limited to a maximum of 240 units per a 14-consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Intermittent Employment and Community Wraparound (limited to no more than 160 quarter hour units in a 14-day billing period and no more than 3,888 quarter hour units/year limit)	X	X	X
Community Participation (all employment/day services combined are limited to a maximum of 240 units per a 14-consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Facility-Based Day (may only be authorized for up to six (6) months at one time; all employment/day services combined are limited to a maximum of 240 units per a 14-consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Non-Residential Homebound Support (24 units per day; limited to a maximum of 10 days in a 14-day billing cycle and maximum of 243 days per person per calendar year)	X	X	X
Individual Transportation (limited to maximum of 31 days/units per month)	X	X	X
Occupational Therapy (limited to 1 assessment with plan development per month; 3 assessments per year per provider; 1.5 hours per day for services other than assessments)	X	X	X
Physical Therapy (limited to 1 assessment with plan development per month; 3 assessments per year per provider; 1.5 hours per day for services other than assessments)	X	X	X
Speech, Language, and Hearing (limited to 1 assessment with plan development per month; 3 assessments per year per provider; 1.5 hours per day for services other than assessments)	X	X	X

Benefit	Self-Determination	Statewide	CAC
Behavior Services (limited to 8 hours per assessment for completion of the behavior assessment; 2 assessments per calendar year, 6 hours per assessment for behavior plan development and staff training during the first 30 days following its approval; 2 assessments per year 5 hours for presentations at meetings per calendar year)	X	X	X
Orientation and Mobility Services(limited to 1 assessment with plan development per month; 3 assessments per year per enrollee per provider; and 52 hours of non-assessment services per calendar year)	X	X	X
Nutrition (limited to a maximum of six (6) visits per waiver participant per calendar year of which no more than one (1) visit per waiver program year may be a Nutrition Services assessment; services other than the assessment (e.g., service recipient-specific training of caregivers; monitoring dietary compliance and food preparation) shall be further limited to a maximum of one visit per day)	X	X	X
Nursing (limited to a maximum of 48 units (12 hours) per day)	X	X	X
Adult Dental (limited to a maximum of \$5,000 per calendar year and a maximum of \$7,500 per 3 consecutive calendar years)	X	X	X
Respite (limited to a maximum of 30 days per calendar year)	X	X	X
Behavioral Respite (limited to a maximum of 60 days per calendar year)	X	X	X
Semi-Independent Living (limited to 1 unit per month (monthly), 31 days per month (regular daily), and 30 days per month (enhanced daily))	X	X	X
Supported Living (limited to 31 days/units per month; 14 days per year for out of state services)		X	X
Residential Habilitation (limited to 31 days/units per month; 14 days per year for out of state services)		X	X

Benefit	Self-Determination	Statewide	CAC
Family Model Residential (limited to 31 days/units per month; 14 days per year for out of state services)		X	X
Medical Residential (limited to 31 days/units per month; 14 days per year for out of state services)		X	X

Amerigroup assists the ISCs with the coordination of covered Medicaid services with services provided by 1915(c) waiver providers to minimize disruption and duplication of services.

If a member receiving home health or private duty nursing services will be subject to a reduction in covered services provided by Amerigroup upon turning twenty-one (21) years of age and the member also receives 1915(c) HCBS Waiver services, Amerigroup will work with DIDD, and the Independent Support Coordinator (ISC) as applicable to coordinate benefits to implement any changes in 1915(c) HCBS Waiver Services at the same time that MCO services are reduced to ensure as seamless a transition as possible. If a member is enrolled in a 1915(c) HCBS Waiver and has a need for supports not available in that Waiver or requests transition to CHOICES or ECF CHOICES, Amerigroup shall refer that member to TENNCARE for transition as appropriate.

During the development of the Person-Centered Support Plan, the Independent Support Coordinator will coordinate with the Member’s assigned MCO Home Health, Private Duty Nursing, Occupational Therapy, Physical Therapy, Speech or Behavior Services, Durable Medical Equipment, and other applicable benefits the member is receiving from their MCO, will document such services in the PCSP, and will ensure that, in the development of the PCSP, Waiver services do not supplant benefits that are available to the member through their Medicaid Benefits/MCO.

The Coordination of Benefits Protocol, which outlines the process of coordinating benefits for members receiving services through the 1915(c) Waivers, can be found on TennCare’s LTSS Protocol Webpage.

Service Definitions

Behavior services

Behavior services must be provided in accordance with HCBS waiver definitions provided on DIDD website and the person-centered planning provisions and rights protection provisions of the CMS HCBS Setting Final Rule. (See section 3.1.a for a discussion of the CMS Final Rule: Person Centered Planning Process.) Behavior services include Assessment, Behavior Services: Planning and Development, Behavior Services: Other, and Behavior Services: Presentation at Meetings. The process for the provision of Behavior services has four (4) stages. They are: 1) Assessment: Completion of a Behavior Services Assessment Report, 2) Planning: Completion of a Behavior Support Plan or Staff Instructions, 3) Follow-up: Completion of Clinical Service Reviews, and 4) Discharge.

Providers can find the Behavior Services and Associated Supports for MCO Members Receiving 1915(c) Waiver Services on the TennCare LTSS Protocol Webpage.

Behavioral Safety Interventions

Behavioral safety interventions (e.g., supported recovery, safety delay, or manual restraint) are procedures that prevent harm to the member or others and shall only be used when alternative strategies are ineffective, and the behavior of a member poses an imminent risk of harm to self or others.

Specialized Behavioral Safety Interventions

Specialized behavioral safety interventions (e.g., supported recovery-separation, mechanical restraint, or protective equipment) are only used in emergency circumstances, but go beyond what is required to resolve the immediate crisis. Specialized behavior safety interventions are only used when there is a persistent and ongoing risk of harm to self or others. Implementation of these procedures requires the consent of the member and or legal representative. The consent should be obtained during a time that the member is not in crisis and is supported to understand that when they are in crisis these procedures may be necessary.

DIDD has designated three (3) classifications of behavioral treatment interventions: unrestricted interventions, restricted interventions, and special individualized interventions. Behavioral safety interventions and specialized behavioral safety interventions are classified separately because they are used to address safety concerns and are not used for treatment. In accordance with DIDD licensure rules highly restrictive and intrusive behavioral safety interventions require review and approval by both the Regional and Statewide BSCs (i.e., supported recovery-separation, mechanical restraint, protective equipment, and specialized behavioral safety interventions).

- a. Specialized behavioral safety interventions may only be used in the crisis section of a BSP.
- b. Devices used as mechanical restraint or protective equipment shall be commercially produced and in good repair.
- c. BSPs involving the use of specialized behavioral safety interventions shall include clear descriptive criteria for the initiation and termination of the procedure in accord with the procedural definitions.
- d. Specialized behavioral safety interventions shall require the initial and annual consent of the member or legal representative, if applicable, and approval of the Regional and Statewide BSCs prior to implementation. Review by an HRC may be required. See DIDD policy 90.1.3 Human Rights Review Process.
- e. Behavior service providers may request a reporting variance from DIDD Coordinator of Behavioral and Mental Health Services when uses of specialized behavioral safety interventions are anticipated to exceed ten (10) uses per month. A form for these requests may be found at DIDD website, https://www.tn.gov/content/dam/tn/didd/documents/divisions/health-services/Reporting_Variance_Request_Form_8_3_2015.pdf.
- f. Because of these risks to the member and to comport with the HCBS Settings Final Rule the following person-centered practices and precautions shall be followed.
 1. The potential for use of restraints must be identified in the PCSP only if the member or legal representative, if applicable, consents. The potential use of restraints must be discussed by the COS.
 2. Restraints are only used to ensure the safety of the member and others.
 3. Restraints are only used as specified in the PCSP or for emergency circumstances and not as an ongoing intervention or treatment.
 4. All staff supporting the person must be trained in the use of restraints.
 5. The PCSP must indicate what positive interventions have been used prior to the use of restraint.
 6. The PCSP must indicate what has been tried before but did not work.
 7. The PCSP must indicate timelines for periodic reviews to determine if restraints are still necessary and plans must be reviewed on an individual basis.

- g. General Precautions in the Use of Behavioral Safety Interventions. Restraints and protective equipment may be used only when necessary to protect the member or others from harm and when less-intrusive methods have been utilized and found to be ineffective in maintaining the safety of the member and others. The application of restraint or protective equipment must be implemented carefully to ensure protection from harm and to protect the rights of the member. Use of restraints and protective equipment carry the risk of psychological trauma, positional asphyxiation, restriction of circulation, and pressure on the muscular and skeletal system. Restraints and protective equipment may not be used excessively, for a time period beyond that which is necessary to ensure safety, as treatment or punishment, for staff convenience, or as a substitute for other services.
- h. The physical condition of the person being restrained or protected shall be evaluated continuously throughout the restraint. People showing abnormalities of breathing, skin color, or other abnormalities shall be immediately released from restraint.
- i. Restraint or Protective Equipment shall not be used when such use is contraindicated. Medical conditions which may contraindicate physical restraints are head or spinal injury, fracture, and pregnancy. Relative contraindications include: osteoporosis or history of fracture; asthma; seizures; heart disease, including hypertension; recent history of surgery; and a history of abuse.
- j. The risks and benefits of restraint in response to these relative contraindications must be evaluated by the COS in consultation with the primary care physician to determine an appropriate course of action. The results of the individualized risk-benefits analysis shall be reported in the document that outlines the use of the restraint or protective equipment.

Prohibited Procedures:

DIDD prohibits procedures that cause harm to or violate the human rights of a member. The following procedures are prohibited.

- a. **Chemical restraint.** Chemical restraint is defined as the inappropriate use of a medication prescribed to control behavior or to restrict the movement of the member for convenience or as a punishment.
- b. **Prone and supine restraints.** Horizontal restraint of a member in a face-up or face-down position. Side immobilizations are not prohibited if they are part of a DIDD-approved Crisis Intervention System. A list of DIDD-approved Crisis Intervention Systems may be found at DIDD website.
- c. **Take downs.** Forcibly moving a member from a vertical (standing or seated) position to a horizontal position. Side immobilizations may be used only when the member is already in a horizontal position and is continuing to pose a risk of harm.
- d. **Seclusion.** Seclusion shall mean placing a member in a room alone while holding or locking the door or otherwise preventing egress.
- e. **Noxious or painful stimuli.** Events that a member may describe as unpleasant to the senses or that result in tissue damage or lasting impairment.

Therapeutic and therapy related services

Therapeutic services for adults with intellectual disabilities are geared towards habilitative services to promote new skills necessary to overcome barriers, chronic care supports designed to prevent or slow Therapeutic Services Progression of chronic health-related conditions, improve or gain functional skills through adaptations, and assist in maintaining optimal health and function across time as people age. In addition, when acute health events happen, therapeutic services are often necessary to pick up where acute services end in order to help ensure a member gets back to his/her prior functional level or as close to it as possible. Therapeutic services include Occupational Therapy (“OT”), Physical Therapy (“PT”), Speech Language Pathology (“SLP”), Audiology, Orientation and Mobility (“O&M”), and Nutrition. Therapy-related services include Environmental Accessibility Modifications (“EAM”) and Specialized Medical Equipment Supplies and Assistive Technology (“SMESAT”).

Therapeutic services require an integrated approach with members and their families, Personal Assistants (“Pas”), agency staff, Direct Support Professionals (“DSPs”), and other health professionals to ensure success in meeting individualized goals. This is accomplished through the implementation of direct therapeutic interventions, training of caregivers on strategies to be implemented throughout the day of a member, and periodic monitoring of the ongoing implementation of written strategies by caregivers and the status of adaptive devices to ensure the member remains healthy, safe, and is able to function across environments.

Descriptions of services are available online at:

https://www.tn.gov/content/dam/tn/didd/documents/divisions/health-services/Reporting_Variance_Request_Form_8_3_2015.pdf

The Therapeutic Services for MCO Members Receiving 1915(c) Waiver Services Protocol can be found on the TennCare LTSS Protocol webpage.

Nursing, and Dental Services

The below are the remaining professional and clinical services available within DIDD system but not covered in previous definitions.

Nursing Services:

Waiver Definition for Nursing Services

The waiver definition shall apply to all nursing services provided in a Medicaid waiver. The waiver definition shall also be used to define nursing services provided in other DIDD-funded programs.

Nursing Assessments

Nursing assessment is not a separate billable service.

Planning Nursing Services

Nurses are required to develop a nursing Plan of Care (“POC”), which must be consistent with action steps and outcomes specified in the PCSP. The nursing POC must be guided by the specific nursing activities ordered by the physician, including the amount, frequency, anticipated duration, type and scope of services required. The nursing POC must be consistent with and reflective of the outcomes and actions specified in the Person-Centered Support Plan (“PCSP”).

2 Rules of the Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-34 Standards for Home Care Organizations Providing Professional Support Services <http://publications.tnsosfiles.com/rules/1200/1200-08/1200-08-34.20170509.pdf>

Obtaining Approval for Nursing Services

The Independent Support Coordinator/Case Manager (“ISC/CM”) will submit the PCSP requesting nursing services to the appropriate DIDD Regional Office. To obtain approval for nursing services, the following requirements must be met:

1. The PCSP must be submitted with a physician’s order.
2. The PCSP must provide documentation of a chronic medical condition requiring the provision of nursing services.
3. The PCSP must provide documentation to justify that the nursing service is medically necessary to ensure the health and safety of the member or to avoid a more costly and restrictive service.
4. The PCSP must include a statement that nursing services are not available or were denied through Medicare, the TennCare Managed Care Organization (“MCO”) program or private health insurance.

Self-Assessment and Internal Quality Improvement (“QI”)

Nursing services providers are required to complete self-assessment and internal Quality Improvement (“QI”) activities that provide an ongoing review of the effectiveness of services provided, identify systemic issues, and initiate corrective actions in a timely manner and before such issues are identified by other monitoring entities. Providers need to document processes used and steps taken/changes made to address issues identified. This information should be made available to others working for the provider. Self-assessment and internal QI activities must be completed annually. Providers shall develop and implement a QI plan to address issues identified through self-assessment activities.

The following components must be included in provider’s self-assessment/internal QI activities:

1. Records management processes.
2. Trends in any event reports completed or investigations involving clinical staff.
3. Review of external monitoring reports and identification of any trends.
4. Review of any personnel practices and any personnel issues.
5. Review of policies and procedures and any updates/revisions needed.
6. Review of a sample of services provided, including people discharged from services, to identify documentation issues and service effectiveness.
7. Review of satisfaction survey processes and results.
8. Steps taken or changes made in response to internal and external review findings, including any sanctions and/or recoupments imposed.
9. Ways the information gained through self-assessment is communicated to other provider staff or those outside of the agency, as appropriate.

Self-assessment and internal QI activities must be completed between DIDD QA surveys and DOH license surveys (as applicable). Providers shall develop and implement a QI plan to address issues identified through self-assessment activities.

Provision of Nursing Services

The types of services performed by nurses are governed by the Tennessee Nurse Practice Act. The Nurse Practice Act allows nurses to perform a number of direct and non-direct functions, although not all of the functions allowed are separate billable services within DIDD system. Services that are billable at the quarter-hourly unit rate are limited to skilled nursing services, such as changing wound dressings, administering injectable medications, and other medications that cannot be administered by direct support staff in accordance with state law.

Documentation of Nursing Services

General requirements pertaining to provider documentation and records maintenance are provided in below in the provider documentation section, which describes records requirements applicable to nursing providers. The amount of nursing units billed must be consistent with the “in/out” times noted in contact notes. Nursing activities completed during visits and any contacts or follow-up activities completed between nursing visits must be documented in contact notes.

Reimbursement Considerations

Nursing oversight by a Registered Nurse (“RN”) is reimbursed only as a part of the service rate for Medical Residential services. The nursing services described in this section of the manual are skilled nursing services. Such nursing services are reimbursed based on the number of units billed. A unit is defined as a quarter (1/4) hour. Reimbursement will not be provided for:

1. Services provided without a physician’s order.
2. Services provided prior to authorization and approval.
3. Services provided that do not require the expertise of a skilled nurse and could be safely performed by direct support staff.
4. Assessment activities not considered a component of the direct nursing service being provided (e.g., If changing a wound dressing, assessment of the wound is a part of the physician ordered nursing activity; however, doing a comprehensive head to toe assessment would not be related.).
5. Services provided to a member in a nursing facility or ICF/IID or within a program operated by a local school system.
6. Time spent waiting for a member to arrive at a particular location.
7. Time spent traveling between service sites to locate the member.
8. Units of service billed, but not supported by required documentation.
9. Visits made for purposes other than the provision of direct, hands-on nursing services (e.g., to perform staff supervisory activities).
10. Time spent performing administrative activities, such as documentation, attending meetings, etc.

Dental Services:

Amerigroup is not responsible for the provision and payment of dental benefits, including dental benefits in the 1915(c) waivers. DIDD will maintain oversight of all functions related to Dental Services, including any future contracting with a DBM

Amerigroup will assist with the coordination of the dental benefits as outlined in the Benefit Management (DBM) Protocol established by TennCare and housed on the TennCare LTSS Protocol webpage.

Respite, Personal Assistance, individual transportation services

Respite Services

Waiver Definition of Respite Services

The waiver definition shall apply to all Respite services provided in a Medicaid waiver. The waiver definition shall also be used to define Respite services provided in other DIDD-funded programs.

Additional Requirements Applicable to Respite Services:

1. The provider must have a Respite license as required by DIDD in the region in which the service is provided.

2. If this service occurs in a licensed residential setting, the person receiving Respite services cannot exceed that home's licensed capacity. If this service is provided under a provider's Supported Living license, the home where the person is supported cannot exceed three (3) members.
3. If this service is provided under an agency's Family Model Residential Supports ("FMRS") license, the home cannot exceed service to three (3) members.
4. The provider must continue implementing PCSP outcomes and actions and must continue to ensure transportation to other necessary services.
5. The provider must ensure management of health care needs, including medical appointments and medication management.
6. General documentation requirements applicable to Residential services providers described in Chapter 10 are also applicable to Respite providers.
7. No more than eighty percent (80%) of the maximum Supplemental Security Income ("SSI") benefit for the current calendar year may be charged to a member for room-and-board expenses by a Respite services provider.
8. Respite services provided eight (8) or less hours a day will be billed at the quarter hour rate and the service will be documented by the quarter hour. For hourly use of Respite services, the use of any part of a day constitutes the use of one (1) of the 30 days per calendar year per person.
9. For Respite services provided over eight (8) hours a day, the appropriate daily Respite rate will be billed, and the service documented by the hour.
10. Levels 1, 2, 3 and 4 Respite and combinations thereof are limited to thirty (30) calendar days per calendar year per person.

Personal Assistance ("PA") Services

Waiver Definition for Personal Assistance ("PA") Services

The waiver definition shall apply to all Personal Assistance ("PA") services provided in a Medicaid waiver. The waiver definition shall also be used to define PA services provided in other DIDD-funded programs. Licensure Requirements.

PA providers must obtain licensure as a home care organization from the Tennessee Department of Health(DOH)) or licensure as a personal support services agency (PSSA) from DIDD or Department of Mental Health Substance Abuse Services (DMHSAS) unless they provide support to only one person.

Employment Services:

Supported Employment—Individual:

Job Coaching: This service is designed to help a member maintain competitive, integrated employment in the community and may also include supports for members engaged in individualized integrated self-employment. Supports may be provided directly or indirectly to the member, his/her supervisor and/or co-workers, but these supports cannot be billed for more hours than the member has worked during the billing period. Supports must be guided by a Job Coaching Fading Plan, which incorporates systemic instruction using task analysis, low- and high-tech assistive technology, and effective engagement of natural supports, as needed. Since fading is expected, multiple levels of reimbursement for job coaching are available to help facilitate the process and may be approved for up to one (1) year in advance. Members are placed in an acuity tier based on an objective level of need assessment and fading expectations for that acuity level.

Stabilization and Monitoring:

Once the support needs of a person are one (1) hour per week or less, Job Coaching through monthly Stabilization and Monitoring will be authorized. This requires a minimum of one (1) monthly face-to-face contact with the member, one (1) monthly contact with the employer (not applicable for self-employment), and the ability of the provider to respond to prevent job loss and/or pursue a change in service authorization, as needed.

A Provider billing only monthly stabilization and Monitoring may also qualify to bill for individual transportation services if needed by the person. However, if the Intermittent Wraparound Service is being utilized, transportation is a component of that service, so an agency providing Stabilization and Monitoring and Intermittent Wraparound Service in the same day cannot bill individual transportation.

Supported Employment—Small Group Employment Support:

This service provides Employment services and training activities to support successful transition to individualized competitive, integrated employment or self-employment, or to supplement such employment when it is only part-time. Group size will not exceed four (4) members. Reimbursement depends on size of group during service. Supports include career planning and exploration activities, discovery classes/activities, and/or paid work on mobile work crews or work enclaves in integrated settings. Members must be paid in accordance with all applicable federal and state labor laws, with the optimal expectation being wages that are at or above the state minimum wage. The PCSP must include what efforts are being made to transition the member to individualized competitive, integrated employment or self-employment and any barriers encountered. Any member using this service to supplement part-time individualized competitive, integrated employment must be offered assistance to increase his/her work hours as an alternative or partial alternative to this service.

The Workforce Investment Act (“WIA”) was changed to the Workforce Innovation and Opportunity Act (“WIOA”) under the Rehabilitation Act, Section 511, which now addresses the payment of sub-minimum wages to youth with disabilities, <https://www.doleta.gov/WIOA/>. WIOA is designed to provide job seekers with access to employment, education, and training needed to succeed in the labor market. Effective July 1, 2016, Section 511 of the Rehabilitation Act requires a series of steps before a member under the age of 24 years can be placed in a job paying less than minimum wage. Section 511 also prohibits schools from contracting with providers that have 14(c) certificates and pay subminimum wages.

Quality Incentive Payments

There are two (2) quality incentive payments available which can be earned by a provider up to two (2) times per year. A provider is eligible for the base fee payment of \$1500 when the member has been employed between 15-19 hours per week in competitive, integrated employment during the previous six-month calendar period (between 390 and 519 hours total). The top tier of \$2000 per member is available for members who worked twenty (20) or more hours per week during the previous six-month calendar period (at least 520 hours total). Providers will submit payment requests using the invoicing form provided by DIDD to the applicable Regional Office administrative unit and must also supply verification of hours worked in the form of pay stubs for reimbursement to occur. Incentive payments for hours worked do not count against the annual member expense cap of members in the Statewide or Self-Determination Waivers.

Employment Data Collection. Employment data must be reported for all members who are receiving Employment, Day, and or Residential services by Independent Support Coordinators/Case Managers (“ISCs/CMs”). Annually, ISCs/CMs are required to complete the **Individual Employment Data Survey (“IEDS”)** with members, unless the person is 62 years of age and has indicated that they are not working and

have no interest in working again. This is a survey that allows DIDD and TennCare to learn about who is employed or interested in becoming employed from the perspective of the member. This is a survey and should not be altered by the interviewer. Information obtained in this survey will be used to help DIDD and TennCare design supports and services to better support members to reach their goals.

Additionally, Supported Employment providers are asked to submit employment data semi-annually (i.e., twice a year in April and November). Providers shall submit employment data using the required online reporting tool, the online tool can be accessed via this link: https://apps.econsys.com/tennessee-data-tracking/users/sign_in.

This employment data collection tool should not be confused with the individual experience assessment, which can be found via the following link:

<https://www.tn.gov/content/dam/tn/tenncare/documents/IndividualExperienceAssessmentSurveyDIDD.pdf>

Utilizing Natural Supports in the Provision of Day Services

The use of natural, or unpaid, supports in the workplace is encouraged. The use of natural supports can be beneficial to the member. Benefits to the member may include increased inclusion in the work environment, development of positive relationships with co-workers, and improved job performance.

Requirements and Limitations of Natural Supports

When natural supports are utilized, the following requirements and limitations will apply:

1. The type and amounts of assistance provided by natural supports must be described in the PCSP and updated during the monthly review process, as needed.
2. Applicable federal and state confidentiality guidelines for sharing information with natural supports will apply (i.e., the member or legal representative will need to consent if Protected Health Information (“PHI”) needs to be shared with co-workers who are not employed by the Day service provider).
3. Work-related natural supports are to be utilized only to provide on-the-job training and support that would be provided to any person hired in a similar position.
4. Natural supports are to be included in the provider’s staffing plan; however, the Day service provider retains responsibility for safety and other requirements associated with the service being provided.

Day Services and Other Service Options

Introduction to Day Services

Day services are individualized services and supports selected by the member that help the member explore and engage in his/her community. The array of Day services offered within DIDD-administered Waivers are intended to ultimately support the attainment of competitive, integrated employment. Services are also attuned to achieving individualized needs and preferences, as reflected in the person-centered Support Plan (“PCSP”). As members move along their journey toward inclusion and pursuit of meaningful employment and social opportunities, some expected outcomes of Day services may include improvement or acquisition of a broader understanding of available community resources, social clubs, or the establishment of true and meaningful relationships that help build natural support networks. Members might receive supports building their understanding of typical processes and social interactions that might assist them in independently engaging in preferred community activities. These supports may include very task-oriented skill building sessions that lead to the ability to independently, or more independently, purchase and pay for goods, or they might be as simple as building confidence and communication skills by facilitating introductions and conversation with people encountered in natural community environments. In short, all Day services are designed to meet members

where they are from a skill and confidence perspective, but also intended to increase those skills, to the extent desired by the member, to allow for a more meaningful and inclusive life.

General Requirements for Day Services:

Providers of Day services are required to abide by the requirements specified in the waiver service definitions, this provider manual, the provider agreement, and other applicable DIDD policies and procedures.

All individual Day services outcomes and action steps, along with needed supports, shall be established through the person-centered planning process and documented in the PCSP and shall include opportunities to engage in community life and control personal resources, as applicable, based on the needs and preferences of the member. DIDD permits flexibility in scheduling the hours that Day services are provided in order to support the goals specified in the PCSP. Except for students who have graduated prior to May 2014, Day services for school-aged members (i.e., under the age of 22) are limited to regular school break periods.

Vocational exploration and discovery-focused vocational assessments may be performed whenever needed and are required at least every three (3) years, unless the member or legal representative (as applicable) has explored what integrated employment is and has decided that s/he does not wish to seek employment and declines to sign a consent for the assessment. For those members who choose other service options, the minimum DIDD requirement is that the option of integrated employment be reconsidered during the Circle of Support (“COS”) meeting and documented during each annual PCSP update.

Providers of Day services are responsible for Personal Assistance (“PA”) needs during the provision of Day services, but PA services cannot be billed separately during the same time period the Day service is billed. A PCSP of a member may include more than one (1) approved service (e.g., Supported Employment, Community Participation, Intermittent Employment and Community Integration Wrap-around Supports, Facility-based Day services, etc.), but more than one (1) service may not be billed during the same 15-minute unit of time.

Transportation of the member to and from the place of residence of the member to the location where Day services will be provided is the responsibility of the Day services provider, with the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol.

Day Service Settings

Day services are required to occur in the most integrated, least-restrictive setting possible, as appropriate to the member. Providers are responsible for ensuring that Day services are provided in settings that comport with the Centers for Medicare & Medicaid Services (“CMS”) Home and Community Based Services (“HCBS”) Settings Final Rule. CMS guidance regarding the settings in which Day services are provided is available online. Providers are required to familiarize themselves with the requirements of the Final Rule. The HCBS Settings Final Rule requires that the setting:

1. Is integrated in and supports full access to the greater community.
2. Is selected by the member.
3. Ensures member rights of privacy, dignity, and respect and freedom from coercion and restraint.
4. Optimizes autonomy and independence in making life choices.
5. Facilitates choice regarding services and who provides them.

Types of Services: Community Participation Supports, Intermittent Employment and Community Integration Wrap-Around Supports, Facility Based Day Supports, Non-residential Homebound Support Services, and Residential Special Needs Adjustment—Homebound.

Community Participation Supports:

The guiding strategy in Community Participation Supports (“CPS”) employs the principles of productivity, inclusion, and independence. CPS services must be structured so that each member has the opportunity to discover his/her skills, interests, and talents in his/her community through engagement, experience, and exploration. CPS services are designed such that the member spends the majority of his/her time, while participating in this service, actively engaged in activities in the community. Supervision, training, education, demonstration, or support is provided to assist the member in accessing, navigating, and using community resources. Desired outcomes of the service are driven by the member and should be documented in the PCSP, along with efforts to form or facilitate development of new relationships with people of all abilities and who are not paid to support the person.

Examples of the implementation of effective CPS include, but are not limited to:

1. Exploring volunteer opportunities or volunteering in the community;
2. Being an active member of the community (examples are being a member of a garden club, neighborhood organization, local gym, etc.);
3. Taking a class in the community to learn a new skill;
4. Participating in age-appropriate experiences that match the interests of the member;
5. Developing age-appropriate hobbies that match the interests of the member;
6. Training in a specific skill the member wants to learn;
7. Using community resources, such as public transportation;
8. Participating in opportunities focused on training and education for self-determination and self-advocacy;
9. Maintaining existing and developing new relationships with individuals of the broader community (e.g., neighbors, co-workers and other people who do not have disabilities and are not paid or unpaid caregivers);
10. Participating in activities that promote health and wellness.

It is expected that use of enabling technology, establishment of natural supports, and fading of paid supports is actively considered and ultimately demonstrated as members gain independence through ongoing participation in community activities.

Intermittent Employment and Community Integration Wrap-Around Supports:

Intermittent wraparound supports are expressly designed to support members with engaging in integrated community participation and integrated employment when sustained all-day participation in these opportunities outside the home is not possible. For members who cannot participate in all-day employment or community participation services, intermittent wraparound supports enable members to use their home as the base from which to start and end their day; and to be home before, after, or in between employment or integrated community activities during the day to attend to personal care needs, receive personal assistance with meals, or to regain stamina before continuing additional community activities. The focus of intermittent wraparound supports is on daily living skills and community living, as reflected in the PCSP.

The intermittent wraparound service must be provided in the residence of the member and cannot be shared with members from other households. The intermittent wraparound service may be billed for up to four (4) hours on days the member spends at least two (2) hours (hours do not have to be consecutive) in Supported Employment or CPS, but may not be billed in conjunction with Facility-based Day services or Homebound Supports.

For members who are of retirement age who do not wish to leave the home, the COS may want to discuss whether the member is able to spend some time alone, and whether this is an opportunity for the member to be more independent. Members who choose to stay at home may be able to do so with the support of Enabling Technology.

Facility-Based Day Services

Facility-based Day services may be provided in a facility setting only when selected by a member who needs time-limited pre-vocational training when such training is not available on the job site. Facility-based Day services may also be provided to members who choose through the person-centered planning process to participate in a facility-based program in order to focus on the development of individualized and specific skills that will support them in pursuing and achieving community living goals. Facility-based Day services must allow for opportunities for all members to be engaged in the broader community when appropriate and be specified in the PCSP. Opportunities to transition into more integrated settings, including competitive, integrated employment, must be evaluated at least every six (6) months. Providers should refer to the joint TennCare and DIDD memos issued on July 16, 2015, and June 20, 2016, regarding appropriate billing of Facility-based Day services ³, which can be found on DIDD website, <https://www.tn.gov/didd/search-results.html?q=authorization+changes+for+facility+based+day+services>. It should be noted that the joint memos referenced above are consistent with CMS guidance issued in 2011 ⁴, <https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf>.

Homebound Support Services:

Non-residential Homebound Support services are for members who live at home with family or in their own home. Residential Special Needs Adjustment—Homebound is for members who reside in Supported Living, Family Model Residential Services, or Residential Habilitation settings.

Homebound Support services may be authorized only when a member meets the definition of “homebound” and is unable (not unwilling) to participate in Employment or Day services and needs to remain at his/her residence for the full twenty-four-hour day, except for leaving the home for medical treatment and/or medical appointments.

Approval for Homebound Support services is determined by an Interagency Committee composed of DIDD and TennCare staff and must be reviewed and reauthorized every ninety (90) days. To qualify for Homebound Support services, the member must be unable to participate in employment or community activities due to one or more of the following documented exceptional conditions:

1. End of life issues.
2. Sustained behavioral crisis.
3. Recovery after a period of hospitalization.
4. Significantly compromised health.

³ https://www.tn.gov/didd/search-results.html?q=authorization+changes+for+facility+based+day+services_

⁴ https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf_

Short Term Stay

In addition to the benefits specified above which will be delivered in accordance with the definitions, including limitations set forth in the approved 1915(c) waiver and in TennCare rule, a member enrolled in a 1915(c) waiver program, may subject to requirements in 2.9.7.3.27.11 receive short-term care (i.e., no more than ninety (90) days) in a nursing facility or ICF/IID without being required to disenroll from their 1915(c) waiver program, until such time that it is determined that transition back to the 1915(c) waiver services will not occur within ninety (90) days from admission.

Amerigroup will review all requests for short-term NF or ICF/IID stays and shall authorize and/or reimburse short-term NF or ICF/IID stays for 1915(c) waiver members only when (1) the member is enrolled in a 1915(c) waiver program, and receiving HCBS upon admission; (2) the member meets the applicable institutional level of care in place at the time of admission (i.e., NF level of care for a short-term NF stay and ICF/IID level of care for a short-term ICF/IID stay); (3) the Member's stay in the facility is expected to be less than ninety (90) days; (4) the member is expected to return to receiving 1915(c) waiver services in the community upon its conclusion; (5) with regard to short-term NF care, the PASRR process is complete, the person's short-term stay is appropriate, and all applicable specialized services have been arranged; and (6) DIDD has reviewed and approved the request prior to admission and the start of the short-term stay in a NF or ICF/IID for any member with I/DD in an HCBS setting unless the STS is for rehabilitation or recovery from the same condition as treated in the hospital. In this case, only notification to DIDD is required. Amerigroup shall provide such notification to DIDD within five (5) business days of the person's admission to the NF, or of knowledge of such admission if the Amerigroup is not notified until after the admission occurred.

Within fifteen (15) days of admission (or knowledge of the admission if Amerigroup is not notified until after the admission occurred), Amerigroup shall work with the member (and his/her representative, as applicable) and the ISC or DIDD Case Manager, as applicable, to develop and submit a transition plan to DIDD for review and approval. If the member (or his/her health care representative) is unwilling to engage in transition planning, Amerigroup shall continue to engage the member on each subsequent visit. Amerigroup shall monitor all short-term NF and ICF/IID stays for 1915(c) waiver programs and shall ensure that the member is disenrolled from the 1915(c) waiver program if a) it is determined that the stay will not be short-term, or the member will not transition back to HCBS; and b) prior to exhausting the ninety (90)-day short-term NF or ICF/IID benefit.

The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year; however, the visits shall not be consecutive. Further, Amerigroup shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to a 1915(c) waiver program is appropriate.

Amerigroup shall monitor, on an ongoing basis, members utilizing the short-term NF or ICF/IID benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each 1915(c) waiver member utilizing the short-term NF or ICF/IID stay benefit, including but not limited to the name of each 1915(c) waiver member receiving short-term NF or ICF/IID services, the NF or ICF/IID in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF or ICF/IID stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF or ICF/IID stay, the Amerigroup shall include explanation regarding why the benefit limit has been exceeded, and specific actions Amerigroup is taking to facilitate discharge to the community including the anticipated timeline.

Person Centered Service Plan (PCSP)

For all 1915(c) waiver programs, the Individual Support Plan (ISP), the person-centered plan for members, developed by the Independent Support Coordinator (ISC) or DIDD Case Manager, as applicable, and Circle of Support will, upon implementation of the IDD Integration be called the Person Centered Support Plan (PCSP).

Independent Support Coordination Agencies are required to share all PCSPs with DIDD per the required timeframes, Amerigroup will have access to all PCSPs for members receiving services through the 1915(c) Waivers and enrolled to receive services with Amerigroup.

A PCSP identifies the needs and preferences of the member as described by that person, in collaboration with family, friends and other team members selected by the member receiving services, so that the member may receive services in the manner they prefer. In addition, the PCSP must reflect the services and supports that are important for the member to meet the needs identified through an assessment of functional need, as well as what is important to the member with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the member and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

1. Assume the person has the rights, freedom, and ability to make his/her own decision and participate in activities of his/her choice.
2. Reflect that the setting in which the member resides is chosen by the member. The setting chosen by the member must be integrated and support full access to the greater community.
3. Include individually identified goals and desired outcomes the person needs support in achieving, including preferences related to relationships; desired engagement in community participation; interest in seeking employment; goals related to personal finances, including income and savings; health; education; and other personal goals.
4. Reflect the services and supports (paid and unpaid) that will assist the member to achieve identified goals and the providers of those services and supports, including natural supports.
5. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
6. Identify the member and/or entity responsible for monitoring the plan.
7. Include those services, the purpose or control of which the member elects to self-direct.

Additionally, CMS Specifies Modifications to the HCBS Settings Rule (i.e., restrictions that are necessary to be placed on someone) must be justified in the Person-centered Plan.

The following requirements must be documented in the person-centered support plan when a modification to the Rule is being requested:

1. Identify a specific and individualized assessed need.
2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include informed consent of the member.

8. Include an assurance that interventions and supports will not cause harm to the member.

Any restrictions on member choice “must be focused on the health and welfare of the member and the consideration of risk mitigation strategies.” The restriction, “if it is determined necessary and appropriate in accordance with the specifications in the rule, must be documented in the person-centered plan, and the member must provide informed consent for the restriction” (<http://www.nasdds.org/news/cms-issues-non-residential-guidance>).

The PCSP must be reviewed and revised upon reassessment of functional need as required at least every twelve (12) months, when the Member’s circumstances or needs change significantly, or at the request of the person.

The person-centered planning process will be led by the member where possible. The person’s representative should have a participatory role, as needed and as defined by the member. In addition to being led by the member the person-centered planning process:

1. Includes people chosen by the member.
2. Provides necessary information and support to ensure that the member directs the process and is enabled to make informed choices and decisions.
3. Is timely and occurs at times and locations of convenience to the member.
4. Reflects cultural considerations of the member and is conducted by providing information in plain language and in a manner that is accessible to the member and people who are limited English proficient.
5. Includes strategies for resolving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
6. Offers informed choice to the member regarding the services and supports they receive and from whom.
7. Identifies clinical and support needs through an assessment of functional need.
8. Is conducted to reflect what is important to the person to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
9. Identifies the strengths, preferences, and the desired outcomes of the member.
10. Includes a method for the member to request updates to the plan, as needed.
11. Prevents the provision of unnecessary or inappropriate services and supports.
12. Records the alternative home and community-based settings that were considered by the member.
13. Is signed by member, all other individuals and providers responsible for its implementation and a copy of the plan is distributed to the member and his/her legal representative, if applicable, and other people involved in the plan.

All PCSPs should be created utilizing person-centered thinking skills, which include the use of person-centered thinking tools, to support the member in developing the PCSP.

PCSPs will include a back-up plan for members receiving non-residential 1915(c) waiver HCBS in their own home and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled 1915(c) waiver HCBS providers or workers are unavailable or do not arrive as scheduled. A 1915(c)-waiver member or his/her representative may not elect, as part of the back-up plan, to go without services. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services.

The Circle of Support (COS)

The COS is always driven by the member and his/her legal representative, if applicable. The member and legal representative, if applicable, identifies and determines who participates in the COS. The goal of the COS is to assist the member in developing the PCSP that will guide the achievement of the Member's outcomes. A member may choose to change the individualship of the COS at any time. Typically, the COS includes the member, his/her legal representative, the Member's family, the ISC/CM, any providers authorized to provide services (to include the direct support professional (DSP)), and/or family members, as applicable. The member can also invite friends, advocates, or any other non-paid supports.

The member and his/her legal representative, if applicable, should drive the direction of the COS.

Authorizations for Services in the PCSP

Providers will be approved to provide services to members with intellectual disabilities, which may be rendered only upon authorization by DIDD pursuant to an approved PCSP.

Any payment for services is limited to and in accordance with the approved PCSP or PCSP amendment for such services.

1. Provider payment shall be contingent upon the satisfactory completion of authorized, approved service as specified in the PCSP or PCSP Amendment.
2. DIDD will refuse payment to the Provider for services billed to DIDD that are beyond the level of services authorized by DIDD through PCSPs or PCSP Amendments, exceed payment rates for these services or are not billed to DIDD within the appropriate time frame after the delivery of services.

Independent Support Coordination and DIDD Case Management

Independent Support Coordinators (ISCs) will facilitate the continuous process of assessment, planning, implementation, coordination, and monitoring of services and supports that assist members with intellectual and developmental disabilities to identify and achieve individualized goals related to work (in competitive, integrated employment), personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness as specified in the Person-Centered Support Plan (PCSP), and the tracking and measurement of progress and outcomes related to such individualized goals, as well as the provider's performance in supporting the person's achievement of these goals. 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.

Support Coordination provider agencies will:

Ensure that all person employed to render support coordination services (Independent Support Coordinators or ISCs) receive effective guidance, mentoring, and training, including all training required by TENNCARE and DIDD. Effective training shall include opportunities to practice support coordination duties in a manner that development and mastery of essential job skills. The intent of providing independent support coordination is to ensure that planning and coordination of services is conflict-free. Thus, providers of independent support coordination services are prohibited from providing both support coordination and other direct waiver services. Support Coordination providers must maintain an office in each grand region where services are provided.

Provide Support Coordination services in a manner consistent with the 1915(c) waiver, TennCare rules, policies, protocols and this Contract.

Provide Support Coordination services in a manner that ensures person-centered planning processes and practices are followed in compliance with 42 CFR § 438.208 and 42 C.F.R. § 441.301(c)(4)-(6) and that comports fully with standards applicable to person-centered planning for services delivered under Section 1915(c) of the Social Security Act.

Initiate and oversee at least annual reassessment of the Member's level of care eligibility, including initial and at least annual assessment of the Member's experience to confirm that the setting in which the member is receiving services and supports, which fully comply 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 Member's specific assessed need and set forth in the PCSP.

Support the Member'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 members not receiving Medicaid HCBS.

Implement the Employment Informed Choice (EIC) process for members in each of the 1915(c) Waivers with the expectation of exploring employment and supporting the member with making informed choices about work and other integrated options. Details regarding the EIC process can be found in the Employment Informed Choice Protocol located on TennCare's LTSS Protocol webpage.

Coordinate with Amerigroup to support any member receiving HCBS and enrolled in the Statewide or CAC Waivers planning and implementing as seamless a transition as possible from early and periodic screening, diagnostic and treatment (EPSDT) benefits to adult benefits, including any coordination of 1915(c) HCBS with State Plan HCBS – Home Health and Private Duty Nursing services, as applicable, and in accordance with this Contract or TennCare policies and protocols.

Ensure compliance with and reporting of specified waiver performance measures related to the PCSP, including;

- PCSP inclusion of a risk assessment
- PCSP inclusion of a medical assessment, whether applicable
- PCSP review and revision, as needed, prior to the annual due date
- PCSP revisions completed as needed to address Member's changing needs
- Ensure member received services for the amount, duration, and frequency as well as type and scope specified in the approved PCSP
- Track and report member quality outcomes data as required by TENNCARE to measure provider and system performance

Specific tasks performed by the Support Coordination entity (ISC or DIDD Case Manager for 1915(c) waiver members) shall include, but are not limited to:

- General education about the waiver program and services, including member rights and responsibilities; providing necessary information and support to the member to support his/her direction of the person-centered planning process to the maximum extent desired and possible
- Initial and ongoing assessment of the Member's strengths, needs and preferences, including an understanding of what is important to and important for the member and the development of a PCSP that effectively communicates that information to those providing supports

- Identification and articulation in the PCSP of the person's individualized goals related to work, personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness, and actions necessary to support the person in achieving those outcomes
- Leveraging member strengths, resources and opportunities available in the person's community, and natural supports available to the person or that can be developed in coordination with paid waiver services and other services and supports to implement identified action steps and enable the person to achieve his/her desired lifestyle and individualized goals for employment, personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and self-determination, and personal health and wellness;
- Initial and ongoing assessment of how Enabling Technology could be used to support the person's achievement of individualized goals and outcomes and planning and facilitation of Enabling Technology supports, as appropriate to include, completion of an Enabling Technology Screening form and an Enabling Technology Plan when enabling technology is being used;
- Facilitating an employment informed choice process with the expectation of exploring employment and supporting the person to make informed choices about work and other integrated service options;
- Actual development, implementation, monitoring, ongoing evaluation, and updates to the PCSP as needed or upon request of the member;
- Additional tasks and responsibilities related to consumer direction of services eligible for consumer direction, as prescribed by TENNCARE
- Coordination with the Member's MCO (applicable for ISCs and DIDD Case Managers) and physical and behavioral health care providers and HCBS providers to improve and maintain health, support personal health and wellness goals, manage chronic conditions, and ensure timely access to and receipt of needed physical and behavioral health services
- Supporting the Member'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 members not receiving Medicaid HCB
- Assuring the personal rights of freedoms of persons supported, and supporting dignity of choice, including the right to exercise independence in making decisions, and facilitation of supported decision making when appropriate
- Identification and mitigation of risks to help support personal choice and independence, while assuring health and safety; specific documentation of any modifications to HCBS settings requirements based on the needs of the member and in accordance with processes prescribed in federal and state regulation and protocol
- Monitoring implementation of the PCSP 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 PCSP is not being implemented. The Support Coordination entity will provide the member with information about self-advocacy groups and self-determination opportunities and assist in securing needed transportation supports for these opportunities when specified in the PCSP or upon request of the member.
- Implement the Employment Informed Choice (EIC) process for members in each of the 1915(c) Waivers with the expectation of exploring employment and supporting the member with making informed choices about work and other integrated options. Details regarding the EIC process can be found in the Employment Informed Choice Protocol located on TennCare's LTSS Protocol webpage.

End of Life Issues

1. Every person has the right to make Advance Medical Directives in accordance with Tennessee and Federal law.
2. The ISC must ascertain the person's wishes concerning life-sustaining treatment as a part of the preparation processes carried out around the time of the annual ISP process. This information must be documented in the ISP.
3. The ISC will address end of life decisions, including autopsy; Physician's Orders for Scope of Treatment (POST), which includes do not resuscitate (DNR) orders; and advance directives for all members served.

Amerigroup shall require that all 1915(c) waiver Independent Support Coordination providers participate in education and training activities as required by Amerigroup to understand physical and behavioral health benefits, and collaborate with Amerigroup to ensure continuity and coordination among physical health, behavioral health, and long-term services and supports, and to ensure collaboration among physical health, behavioral health, and long-term services and supports providers pursuant to protocols, policies and procedures developed or approved by TENNCARE. Amerigroup will also require all ISCs supporting members in the 1915(c) participate in Consumer Direction (CD) Training and are knowledgeable of all requirements of CD per the Consumer Direction Cost Effective Alternative (CEA) Protocol.

Caseload Size

Support Coordination Agencies shall arrange member caseloads within the maximums and under the conditions established below, as needed to meet the needs of the members on those caseloads.

Maximum Caseloads for Independent Support Coordinators (ISC):

An ISC shall not be assigned a total caseload of more than thirty-five (35) people, except in cases of the following situations below,

Exceeding Maximum Caseloads:

ISC caseload maximums may be exceeded due to staff illness, vacation, or attrition if:

- The situation is temporary. The Support Coordination agency must be actively working to resolve the staff shortage, as evidenced by current advertisements to fill positions, job interviews, etc.
- There is sufficient staff to ensure that support coordination responsibilities are met and each person's needs in regard to support coordination services are satisfactorily met.

DIDD Case Manager

A qualified individual employed by DIDD who provides support coordination services to members in the Self-Determination Waiver and is responsible for, the assessment, planning, implementation, coordination, and monitoring of services and supports that assist members with intellectual and developmental disabilities enrolled in the program to identify and achieve individualized goals related to work (in competitive, integrated employment), personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness as specified in the Person-Centered Support Plan (PCSP), and the tracking and measurement of progress and outcomes related to such individualized goals, as well as the provider's performance in supporting the person's achievement of these goals.

Consumer Direction

Consumer direction (also referred to as self-direction) is a process by which eligible 1915(c) waiver HCBS are delivered; it is not a service. If a member chooses not to direct his/her care, he/she shall receive authorized 1915(c)

waiver HCBS through contract providers. While the denial of a member's request to participate in consumer direction or the termination of a member's participation in consumer direction gives rise to due process including the right to fair hearing, such appeals shall be processed by the TennCare Division of Long Term Services and Supports rather than the TennCare Solutions Unit, which manages medical appeals pertaining to TennCare benefits (i.e., services).

Members who participate in consumer direction of eligible 1915(c) waiver HCBS choose either to serve as the employer of record of their workers or to designate a representative to serve as the employer of record on his/her behalf.

Independent Support Coordinators will offer 1915(c) Waiver members, as applicable through the comprehensive needs assessment/reassessment process, who need personal assistance, respite or individual transportation services, and/or any other services specified in the TennCare rules and regulations as available for consumer direction. Consumer direction in the 1915(c) waiver affords members the opportunity to have choice and control over how eligible 1915(c) waiver HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TennCare.

For 1915(c) waiver members, Amerigroup with TennCare has developed a Consumer Direction protocol that provides detailed guidance regarding the Independent Support Coordinator's (ISC) responsibilities pertaining to Consumer Direction.

The Consumer Direction Cost Effective Alternative (CEA) Protocol can be found on TennCare's LTSS Protocol webpage.

Rights

People with intellectual disabilities have the same rights as other people, unless their rights have been limited by court order or law. People do not give up their rights when they accept services from DIDD or other state programs. There are basic human and civil rights that are protected by the United States Constitution, and state and federal laws. Many of these laws take the form of protecting people from discrimination. People with intellectual disabilities must be treated fairly and equally when services are being developed and provided. People with intellectual disabilities are entitled to the same human rights as those of individuals who do not have intellectual disabilities. Please reference *The Universal Declaration of Human Rights* via the following link: <https://www.un.org/en/about-us/universal-declaration-of-human-rights>. Provider agencies must adhere to 45 C.F.R. 84 and Title 33 of the Tennessee Code as the primary laws governing the methods employed in service delivery to people with intellectual disabilities.

Title VI of the Civil Rights Act of 1964 prohibits certain types of discrimination in programs that utilize federal funds. Medicaid waivers are programs that are partially funded with federal dollars. MCOs, DIDD and providers must comply with Title VI requirements. Providers must not exclude, deny benefits to, or otherwise discriminate against any applicant for services or member based on race, color, or national origin in the admission to or participation in or receipt of the services and benefits of any of its programs and activities. Prohibited practices include, but are not limited to, the following:

1. Denying any service, opportunity, or other benefit for which an applicant or member is otherwise qualified because of race, color, or national origin.
2. Providing any member with any service or other benefit which is different or is provided in a different manner from that which is provided to others under the same program because of race, color, or national origin.
3. Subjecting any member to segregated or separate treatment in any manner related to the receipt of a service because of race, color, or national origin.

4. Restricting any member in any way in the enjoyment of services, facilities, or any other advantage, privilege, or benefit provided to others under the same program because of race, color, or national origin.
5. Treating a person differently from others in determining whether such person satisfies any admission, enrollment, quota, eligibility, individualship, or other requirement or condition which people must meet in order to be provided any disposition, service, financial aid, function or benefit provided under the program.
6. Denying a person an opportunity to participate in the program through the provision of services or otherwise or affording such person an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as an employee but only to the extent set forth in regulation).
7. Utilizing criteria or methods of administration which have the effect of subjecting people to discrimination because of their race, color, or national origin or which may have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to people of a particular race, color, or national origin.
8. Selecting site or location of facilities for the purpose or effect of excluding people, denying them benefits, or subjecting them to discrimination under any program on the basis of race, color, national origin or with the purpose or effect of defeating or substantially impairing accomplishment of the objectives of Title VI of the Civil Rights Act of 1964. .
9. Subjecting any member to discrimination on the ground of race, color, or national origin in its employment practices under such program, e.g., recruitment, layoff or termination, or rates of pay.
10. Denying a member the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

PROVIDER REQUIREMENTS

All providers must ensure that members receive equal treatment, equal access, equal rights, and equal opportunities without regard to race, color, or national origin. They are required to take reasonable steps to ensure reasonable access to programs and activities for people with Limited English Proficiency (“LEP”).

Providers must meet the following requirements:

1. Service providers and ISCs/CMs must document that members are informed of Title VI protections and remedies for Title VI violations on an annual basis. This documentation must be filed in the record for the member and available for inspection.
2. All providers must designate a Title VI Local Coordinator.
3. All providers must ensure that members are informed of who the Title VI Local Coordinator is and how to contact him/her.
4. All providers must develop and implement written policies and procedures addressing:
 - a) Employee training to ensure Title VI compliance during service provision.
 - b) Employee training to ensure recognition of and appropriate response to Title VI violations.
 - c) Complaint procedures and appeal rights pertaining to alleged Title VI violations for persons supported.
 - d) Personnel practices governing responses to employees who do not maintain Title VI compliance in interacting with members.
5. All providers must provide or arrange language assistance (i.e., interpreters and/or language-appropriate written materials) to people with LEP at no cost to the person.
6. All providers must provide meaningful access to services to people with LEP.
7. All providers must have a mechanism for advising members regarding the options for filing a Title VI complaint.
8. All providers must display Title VI materials in conspicuous places accessible to members. Materials are available from Local Coordinators, DIDD Regional Office Title VI Coordinators, or DIDD Central Office Title VI Director.
9. Residential providers must ensure that housing decisions and transfers are made without regard to race, color, or national origin.
10. All providers must complete and submit an annual Title VI self-survey in the format designated by DIDD and in accordance with Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition
11. All providers are required to submit the Title VI self-survey covering the previous fiscal year (July 1 through June 30) in the format designated by August 1 of each year.
12. All providers must orient employees to their Title VI responsibilities and the penalties for noncompliance.
13. All providers must ensure that vendors, subcontractors and other contracted entities are clearly informed of Title VI responsibilities and maintain Title VI compliance.

Failure to Maintain Title VI Compliance

Any service provider found to be in non-compliance with Title VI will be provided written notice. Failure to eliminate further discrimination within ninety (90) days of receipt of notice will be considered a violation of the terms of the Provider Agreement and basis for sanctions, contract suspension, or termination.

Individual Rights

Services and supports shall be provided in a manner which ensures people’s rights of privacy, dignity, respect, and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Members through DIDD Waivers shall be entitled to the following rights including, but not limited to:

1. Being treated with respect and dignity as a human being.
2. Having the same legal rights and responsibilities as any other person, unless otherwise limited by law. If there are limits on the person's decision-making, the alternate decision-maker should explain the person's rights and responsibilities and involve the person in the decision-making process to the maximum extent possible. (See section 2.5 for a discussion of alternate decision-makers).
3. Due process under federal and state law.
4. Being involved in any Human Rights Committee formal reviews of restrictions of their rights, emergency PRN psychotropic medication reviews, restitution reviews, and restricted Behavior Support Plans ("BSPs").
5. Receiving information and providing informed consent regarding proposed services and other treatments, rights restrictions, psychotropic medication, and restricted BSPs
6. Receiving services and supports, regardless of gender, race, creed, marital status, national origin, disability, sexual orientation, ethnicity, or age.
7. Being free from abuse, neglect, and exploitation.
8. Receiving appropriate, quality services and supports in accordance with their PCSPs and to driving their own person-centered planning processes.
9. Receiving services and supports in the most integrated and least-restrictive community settings that are appropriate, based on the needs of the member.
10. Having access to and support in understanding DIDD rules, policies, and procedures pertaining to services and supports.
11. Having access to and support in understanding personal records and to have services, supports, and personal records explained so that they are easily understood.
12. Having personal records maintained confidentially.
13. Owning and having control over personal property, including personal funds.
14. Having access to and support in understanding information and records pertaining to expenditures of funds for services provided.
15. Having choices and making decisions.
16. Having freedom of choice of providers and services and supports and the settings in which services and supports are delivered. The setting is selected from an array of options, including those that are non-disability specific.
17. Having privacy and being free from unauthorized intrusion and unwanted observation.
18. Receiving mail that has not been opened by provider staff or others, unless the person or legal representative has requested assistance in opening and understanding the contents of incoming mail.
19. Being able to associate publicly or privately with friends, family, and others.
20. Having intimate relationships with other people of one's own choosing.
21. Practicing the religion or faith of one's choosing.
22. Being free from coercion and the inappropriate use of physical or chemical restraint.
23. Having access to transportation and community settings used by the general public.
24. Being fairly compensated for employment.
25. Seeking resolution of rights violations or quality of care issues without retaliation.

Supporting People to Give Informed Consent

It can be challenging for provider agencies and staff members to support people to exercise their rights, be accountable for their personal responsibilities, and make decisions. When supporting adults, consider the strategies⁵ listed below to help people make decisions that require informed consent.

⁵ The Council on Quality and Leadership, "Consent: What It Really Means" <https://c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/consent--what-it-really-means>

These strategies can be found by visiting The Council on Quality and Leadership, “Consent: What It Really Means” <https://c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/consent--what-it-really-means>.

1. Assume the person has capacity to make decisions about his/her life. Members make decisions daily. Help people to understand different options or the pros and cons of making choices. If necessary, involve the people who know the member best and how he/she communicates his/her preferences when making decisions. If the member has legal representative or conservator, then ensure that individual is authorized to make the decision on the person’s behalf for that particular issue. Additionally, it is equally important for people with legal representatives to be included in making any decisions about their lives and matters that involve them.
2. Support the person to understand the information that is being communicated. Share information in a way that is accessible and understandable so that the person can make decisions voluntarily.
3. Ask the person questions and listen to his/her responses. Provide the person with relevant information in a format that complements the person’s learning and communication styles.
4. Support people to make their own conclusions, even if you don’t agree. There is not a single or perfect answer for most life situations.
5. As needed, involve the person’s legal representative to assist them with the decision-making process.
6. Conduct a formal human rights review if there is the possibility of rights restrictions.
7. Contact the Protection from Harm Unit if there are any concerns about the person’s health, welfare, or safety.
8. Support the person to understand consent forms. Ensure that the consent is time-limited and for a specific purpose.
9. Support the person and others involved (e.g., treatment providers) to understand that the person’s consent can be withdrawn.
10. Do not infer that the person has given consent simply because he/she is involved in a particular program or service.

Death Reporting and Death Reviews

Entities serving members in the HCBS waiver or in a state-operated ICF/IID or developmental center are responsible for reporting the death of such people supported to DIDD and for complying with the Death Review Protocol.

Autopsies

The Department encourages family members and or legal representatives of members to request an autopsy for deaths that are unexpected and unexplained. These autopsies will be performed without cost to the family or legal representative. In the event the family or legal representative objects to the autopsy, the Department will respect their wishes.

Provider Agreements

All provider agreement requirements are outlined within the Contractor Risk Agreement, which can be found on TennCare’s website, <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>

Provider Roles and Responsibilities

All providers that require licensure must obtain the appropriate license prior to contracting with the MCO. It is required that providers maintain licensure for services offered at all times while services are being rendered to 1915(c) Members. Providers that have allowed licensure to lapse will not be reimbursed for services provided

during the lapsed period. Providers will be required to show proof of current licensure during DIDD annual surveys. Proof of licensure may be required during other reviews or surveys, such as those conducted by CMS, the Division of TennCare, the Tennessee Office of the Comptroller, or the Tennessee DOH. Licensure information is available on DIDD website, <https://www.tn.gov/didd/divisions/office-of-licensure.html>.

Personnel Policies are required if staff are employed by a provider. Personnel policies are not required of independent providers or when services are provided only by subcontractor's staff in accordance with an Amerigroup-approved subcontract. Personnel policies must be updated, maintained, and implemented while a Provider Agreement remains in effect. Required personnel policies must address:

1. Procedures for hiring staff, including minimum qualifications for each staff position. Additionally, for including members in the hiring process of staff to the extent they desire, where applicable. For example, direct support professionals staffing supported living homes).
2. Job descriptions for each staff position.
3. Procedures for initiating and resolving employee complaints or grievances.
4. Requirements pertaining to use of employee-owned vehicles to transport members, if applicable.
5. Procedures for progressive employee disciplinary actions, including but not limited to sanctions for Title VI non-compliance, drug-free workplace violations, and substantiation for abuse, neglect, or exploitation of members.
6. Procedures for tuberculosis risk assessment and screening in accordance with current DIDD and DOH licensure requirements. The Adult Tuberculosis (TB) Risk Assessment and Screening Form is available online: https://www.tn.gov/content/dam/tn/didd/documents/providers/forms-tools/health-services/TB_Risk_Assessment_and_Screening_Form.pdf.
7. Procedures for maintaining a drug-free workplace pursuant to Tennessee Code Title 50 Chapter 9 and 42 CFR 2, including the release of an employee's drug and alcohol test results to DIDD for the purpose of internally investigating allegations of abuse, neglect, and/or exploitation of members. As a condition of the person's voluntary employment, a signed consent release shall be obtained at the time of hiring. The release shall be in effect the duration of his/her employment.

Staff employed by providers contracted to provide services within the 1915(c) Waiver must,

1. Be at least eighteen (18) years of age.
2. Staff who have direct contact with or direct responsibility for members must be able to effectively read, write, and communicate verbally in English and read and understand instructions, perform record-keeping duties and write reports.
3. Staff responsible for transporting a member must have a valid driver's license and automobile liability insurance of the appropriate type and minimum coverage limits for Tennessee, as established by the Department of Safety and Homeland Security.
4. Staff who will have direct contact with or direct responsibility for members must pass a criminal background check performed in accordance with T.C.A. § 33-2-1202.

CMS requires that states review and evaluate HCBS waiver settings, including residential and non-residential settings, and demonstrate compliance with the HCBS Setting Final Rules. This rule was developed to ensure that people receiving long-term services and supports through Medicaid-reimbursed HCBS waiver programs have full access to benefits of community living and the opportunity to receive services and supports in the most integrated setting appropriate. New providers of DIDD Residential Habilitation, Family Model Residential Services, Day, and/or Employment services must assess each site that they own, co-own, and/or operate. New providers of DIDD Supported Living services must complete one self-assessment per region. All providers must demonstrate compliance with the Final Rule by providing evidence that policies, procedures, training, and

operating practices are in place and regularly assessed for this compliance. DIDD will work with providers to assure compliance.

Staff who have direct contact with or direct responsibility for members must not be listed on the Tennessee Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender Information List (FOIL), and the Office of Inspector General's List of Excluded Individuals/Entities (LEIE).

Family members who are paid to provide services must meet the same standards as providers who are unrelated to the person.

All providers must comply with DIDD and TennCare policies, procedures, and rules for waiver service providers, as well as quality monitoring requirements.

Require all staff employed by a provider and delivering employment services to 1915(c) members obtain certification and training pursuant to TennCare and DIDD guidance, as required for compliance.

Providers will notify Amerigroup, as expeditiously as warranted by the Member's circumstances, of any known significant changes in the Member's condition of care, hospitalizations, or recommendations for additional services. In turn, Amerigroup will notify the Independent Support Coordinator/DIDD Case Manager.

Primary Provider Responsibilities for Hospitalizations

1. Remain current with changes to health status and support needs of the person to ensure necessary supports are in place to adequately meet the needs of the person upon discharge.
2. Provide the hospital with contact numbers for the ISC/CM, including after-hours contact information, in addition to other contact information such as the legal representative and family.
3. Provide communication links between the person and or legal representative, residential service provider and hospital staff.
4. Collaborate with the legal representative and or the residential provider to ensure the person has adequate supports while receiving in-patient hospital care.
5. Collaborate with hospital discharge planning staff; the legal representative, if applicable; the person's MCO; the residential provider; and, if the person is also Medicare eligible, his/her Medicare provider to identify and obtain any alternative supports and services needed by the person upon discharge.
6. Collaborate with the ISC/CM to ensure the ISP is updated when indicated after discharge to ensure the person's needs are met.
7. Identification of members and/or medical professionals to be contacted and informed when discharge is imminent and/or when alternative placement is needed following discharge.
8. Collaborates with the ISC/CM regarding arrangements to resume or change previous professional services, as appropriate, and/or arrangements for providers of any new services and supports needed post discharge.
9. Collaborate with the ISC/CM regarding arrangements for any environmental modifications, new equipment or supplies needed post discharge.
10. Informs the Day Service provider of the hospitalization and the results. This communication can occur via email or in-person or telephone.

Background Checks

Providers are required to complete **statewide** criminal background checks, including registry checks, as applicable. At a minimum, registry checks shall include a check of the Tennessee Abuse Registry, National and Tennessee Sexual Offender Registry and List of Excluded Individuals/Entities (LEIE). Criminal background checks

and registry checks must be performed on any employee or volunteer who will have direct contact with a member in 1915(c) Waivers. Any employee or volunteer supporting 1915(c) members who will not have direct contact with these members must have required registry checks completed prior to beginning this support.

Unless federal or state laws prohibit individuals with certain criminal records from holding particular positions or engaging in certain occupations, an individual whose background check reveals past criminal conduct shall be given an opportunity to undergo an individualized assessment in accordance with the applicable laws and legal guidance. The requirements for background checks are as follows:

1. A complete work history with a continuous description of activities for the past five (5) years.
2. At least three (3) personal references, including at least one who has known the individual for at least five (5) years.
3. A signed release authorizing information from the background check to be disclosed to the provider.
4. Either fingerprint samples for a criminal history background check conducted by the Tennessee Bureau of Investigation ("TBI") or the Federal Bureau of Investigation ("FBI"), or information for a necessary criminal background investigation to be conducted by a Tennessee-licensed private investigation company.

Additional DIDD Requirements Pertaining to Background Checks

1. For an individual who has lived in Tennessee for one (1) year or less, a nationwide background check is required. Such nationwide background checks may be limited to those states where the person has lived during the past seven (7) years or since the age of eighteen (18) years, whichever is fewer.
2. Individuals who are aged 18 or older who reside in a Family Model home are required to have a background check in accordance with sections 5.2.c and 5.2.d. of this manual.
3. Background checks for subcontracted employees working for a temporary employment service are required to be completed by the FBI, TBI, or a Tennessee-licensed private investigations company and must contain the scope (e.g., local, state, nationwide) of the inquiry.

A new background check is not required to be completed within the thirty-day period if a background check meeting DIDD requirements has already been completed for the subcontracted employee and the subcontracted employee has been continuously employed by the temporary employment service since the initial background check was completed.

1. Providers must maintain records of background checks and registry checks it has conducted on all employees and contract employees for five (5) years after the employment relationship between the provider and the employee has terminated.

This requirement does not supersede or supplement any existing state or federal record retention requirement. This requirement is strictly related to DIDD QA surveys. Each provider should consult with competent legal counsel to ensure compliance with all applicable state and federal record retention requirements.

Reimbursement for Criminal Background Checks

Reimbursement for criminal background checks will be made as follows:

1. The provider requesting the background check will pay the TBI, the FBI, or the Tennessee-licensed private investigation company.
2. DIDD will reimburse the provider for the cost of the criminal background check if the following conditions are met:
 - a. The provider is properly licensed and has been deemed credentialed by DIDD.
 - b. The background checks have been completed by the TBI, FBI, or a Tennessee-licensed private investigation company.

- c. Funding is available for DIDD to make such reimbursement payments.

Training and Staff Development

Initial and Ongoing Staff Training Requirements

Providers must have a process in place to provide and document initial and ongoing education to its employees who will provide services to members that receive services through the 1915(c) Waiver.

Dental services providers and audiology services providers and vision services providers are not considered clinical services staff for purposes of training and are excluded from meeting DIDD training requirements. Also excluded from DIDD training requirements are staff from agencies providing the following: environmental modifications, specialized medical equipment supplies and assistive technology (SMESAT), or personal emergency response systems (PERS).

Most of the required provider training is “competency-based.” This means that a staff person completing the training, via the web-based program or classroom instruction, is required to obtain a score of 80% or better on the post test. Some trainings (e.g., *CPR, First Aid, Medication Administration, Information and Training Specific to the Person*) have a hands-on skills component and proficiency on those skills must be demonstrated for the trainer.

Staff Categories Training Requirements

Specific training courses are identified by staff category, which is defined by functional responsibilities, on DIDD web site, <https://www.tn.gov/content/dam/tn/didd/documents/divisions/training/requirements/Training-Req-for-Provider-Staff-Categories.pdf>. Training course titles may change as content is modified to reflect new CMS requirements or changes to best practice.

Based on Staff Category, providers will ensure its employees will participate in the trainings, at a minimum:

Web-Based or Classroom:

- Reportable Event Management
- Information and training specific to the person
 - Fire Safety and Emergency Evacuations
- Medication Administration for Unlicensed Personnel
- Universal Precautions Training
- Title VI Training
- Health Insurance Portability and Accountability Act (HIPAA)
- HCBS Settings Final Rule Requirements
- Human Rights Training
- Reportable Events Management

External Trainings, which include being certified and recertified,

- CPR with Abdominal Thrust
- First Aid

Timeframes to Complete Required Training

Trainings must be completed within the timeframes described below. For quality monitoring purposes, timeframes are calculated from the employee’s date of hire or appointment date, as designated by the agency.

Phase I or Pre-Service Training for All Staff

Staff must complete this initial training before working alone with a member. This training must be completed within thirty (30) days from date of hire. Prior to completion of Phase I Training, new staff must be accompanied by a fully-trained staff person who assumes the responsibility for providing direct services while mentoring the new employee.

Phase II or Core Training for All Staff

This training is to be completed within sixty (60) days of date of hire. Staff may work alone with members while completing Phase II courses. However, medications shall not be administered by unlicensed staff until successful completion of the course *Medication Administration for Unlicensed Personnel*.

Phase III for Job Coaches only

This training is to be completed within ninety (90) days of date of hire. Staff may work alone with members while completing Phase III courses.

Phase IV Training for ISCs only

This training is to be completed within 120 days of date of hire. Staff may work alone with members while completing Phase IV courses.

Training Documentation

Below outlines DIDD's existing training requirements and best practices. Amerigroup will provide any updated guidance and resources via our provider portal as received by TennCare and DIDD.

Providers may utilize web-based training or choose to complete training using the web-based training materials in a classroom setting. DIDD's preference is that all agencies conduct all testing in the web-based training portal site so that all training is recorded in the Electronic Learning Management ("ELM") system. If web-based testing is prohibitive and an agency elects to conduct testing in a classroom setting, it is essential that test results are manually entered in the ELM for each learner so that the test is captured on the learner's electronic transcript. For courses included in the web-based training program, post-test scores are maintained permanently on the employee's electronic transcript. A hard copy of staff electronic transcripts may be placed in the personnel file. The ELM system provides agencies with the means to enter and track classroom training (e.g., *CPR*, *First Aid*, *Medication Administration for Unlicensed Personnel*) with certification documentation and staff test scores.

Certificates issued by DIDD may be presented as proof of completion of required training, with the exception of *Medication Administration for Unlicensed Personnel*, which needs to be verified with the nursing department of the appropriate Regional Office. For DIDD web-based training course names and the documentation requirements, see the job specific information in this chapter and on DIDD website.

For training on *Information and Training Specific to the Person*, where there is not a written test, competency shall be demonstration of the knowledge and skills required to provide the services or supports with documentation of type of training, date, trainer name, and staff signature.

Providers must maintain documentation of training completed by the volunteers, students, or natural supports. Documentation must include the name of the volunteer, student, or natural support; the name of the person or entity providing the training; a brief description or explanation of the training provided; and the date the training was provided.

The documentation for Member-Specific Training can be completed by using DIDD Personal Training Profile available on DIDD website: <https://www.tn.gov/didd/divisions/training.html>, or a provider-specific format containing the same elements. For any additional training using the web-based venue, the training transcript is acceptable documentation. Training documentation is to be followed as outlined in the provider manual according to the course and/or entity being used.

Training Resources

Staff development opportunities are offered utilizing web-based learning and classroom instruction. Employer mentoring and support ensure a workforce with the basic competencies to support people with intellectual disabilities in achieving life goals based on what is important to them within the context of what is important for them. To complement this chapter and provide additional resources, refer to the training requirements on the Department's website:

<https://www.tn.gov/content/dam/tn/didd/documents/divisions/training/requirements/Training-Req-for-Provider-Staff-Categories.pdf>. This plan includes course and documentation requirements for web-based vendors, as well as other courses provided by DIDD.

In addition to web-based training, DIDD offers important content training on Person-Centered Thinking, PCSP Planning and Implementation, Human Rights Committee training; and skill-based trainings, such as Challenges in Physical Management and Mealtime Challenges. Some of these classes, along with the classes taught by the regional nurse educators, are listed as available upon request, while some are offered each month. The regional training calendars can be found on DIDD website:

<https://www.tn.gov/content/dam/tn/didd/documents/divisions/training/requirements/Training-Req-for-Provider-Staff-Categories.pdf>. To help providers develop the resources needed to deliver and enhance training for their staff and assist in developing training skills for agency staff called upon to be trainers, DIDD offers a course called *Effective Training Techniques* as a first step. Web-based training courses are available to be utilized as classroom training, one-on-one, or in small groups.

If classroom training is utilized, learners have the option of testing on the web learning platform or completing paper tests. Using the web platform for testing ensures all training is reflected on one transcript. If paper testing is used, trainers can enter classroom training as an event with roster and test scores in the web-based training portal. Copies of sign-in sheets with course and instructor name, date, and signature of staff, and individual scored tests (if applicable) are accepted proof of agency classroom training provided to staff and shall be maintained in a training file. The Regional Nurse Educator will maintain the database of all certified RN trainers for *Medication Administration for Unlicensed Personnel* course.

Pre-employment Services

Agency employed staff delivering Supported Employment - Individual Employment Supports services shall also be required to meet the following certification qualifications:

- Exploration and Job Coaching: Staff shall have qualified as a Job Coach by either:
 - Qualifying as a Job Developer
 - Successfully completing a competency-based training course covering best practices in job coaching and consultation, pre-approved by DIDD and covering, at minimum, specific content prescribed in policy by DIDD. For example, but not limited to: *Training Resource Network, Inc. (TRN)* on-line web course *Job Coaching and Consulting: Design, Training and Natural Support*
- Discovery and Job Development: Staff shall have successfully obtained one of the following to qualify as a Job Developer:
 - Association of People Supporting Employment (APSE) Certified Employment Support Professional (CESP) Certificate – received through passing an exam;

- ACRE Basic Employment Certificate – the Supported Employment Online Certificate Series earned through Virginia Commonwealth University;
- ACRE Basic Employment Certificate in Community Employment with Emphasis on Customized Employment, offered by Griffin-Hammis Associates;
- ACRE Basic Employment Certificate – from College of Employment Services (CES) plus offered by University of Massachusetts Institute for Community Inclusion;
- ACRE National Certificate of Achievement in Employment Services earned through University of Tennessee;
- ACRE Professional Employment Certificate earned through completion of “Work Works” on-line course offered by University of Georgia Institute on Human Development and Disability

Frequency of certification verification

- Certification shall be verified annually.

Enabling Technology

The Enabling Technology program has developed standardized training requirements and specified curricula for all staff providing enabling technology supports based on the expectations of their job duties. Staff will be considered to fall within one of the categories as specified *below*.

Specific courses and timelines for completion are identified and outlined in the Enabling Technology Training Requirements for Staff Categories document available on DIDD website:

<https://www.tn.gov/content/dam/tn/didd/documents/divisions/training/requirements/Training-Req-for-Provider-Staff-Categories.pdf>. The training curriculum was developed in partnership with SimplyHome and is made available through the web-based training portal so that all Enabling Technology training is recorded in DIDD electronic learning management (ELM) system.

Provider staff following the Enabling Technology training requirements must also complete all required trainings as outlined by DIDD *Training Requirements for Provider Staff Categories* available on DIDD website. Remote support staff may be subcontracted through an approved Technology Vendor and the provider agency is required to follow the training requirements for Remote Support Staff, per below.

The Enabling Technology Protocol can be found on TennCare’s webpage.

Remote Staff

Remote Support Staff are staff that do not provide direct, hands-on supports and assistance to the members by the agency but do provide indirect supports and services to members from a remote location using enabling technology devices and equipment. Titles of these staff include, but are not limited to remote support professionals, remote caregivers, or remote responders. Remote support staff may be subcontracted through an approved Technology Vendor and the provider agency is required to follow the training requirements of subcontractors as specified in this section.

Medication Safety

Medication Administration by Unlicensed Personnel

A statutory exemption allows unlicensed staff to administer certain medications to persons in DIDD’s waiver programs. Providers who employ staff to administer medication are responsible for compliance under DIDD rules and standards, which can be found via the following resource, rules of the Tennessee Department of Intellectual and Developmental Disabilities Chapter 0465-01-03 Administration of Medication by Unlicensed

Personnel: https://www.tn.gov/content/dam/tn/didd/documents/divisions/health-services/medication-administration/Med_Admin_Rules_Final.pdf. Providers shall ensure that all unlicensed staff who administer medication have successfully completed DIDD Medication Administration for Unlicensed Personnel competency-based training and that current certification is maintained. Providers using the medication administration for unlicensed personnel exemption shall also ensure the following:

- Providers shall have a medication safety policy that is accepted by DIDD. Required elements of a medication safety policy are specified in DIDD rules.
- The medication safety policy shall also contain elements which address self-administration of medications.
- The medication safety policy shall also contain elements which address the safe administration of psychotropic medications, including appropriate screening for medication-induced movement disorders as determined by the practitioner/prescriber, based on his/her clinical judgement and standard of care.
- A separate Medication Administration Record (MAR) must be maintained for each person receiving medications. MAR required elements are specified in DIDD rules.
- Informed consent is required before the prescriber's order is implemented. PRN psychotropic medications may only be administered by a licensed nurse after an RN or prescribing practitioner has determined less-restrictive measures have been taken and failed to stabilize the situation. The provider shall notify the prescriber of each administration of the PRN psychotropic medication within one (1) business day. A summary of all PRN psychotropic medications administered since the previous appointment shall be provided to the prescriber at the time of the person's next quarterly appointment.
 - Human Rights Committee (HRC) formal review is required within 30 days if the member does not consent or refuses the PRN psychotropic medication when administration is attempted.
- Medication variances and omissions can occur during transcribing, preparing, administering, or in the documentation of a medication. A medication variance occurs at any time that a medication is given in a way that is inconsistent with how it was ordered by the prescribing practitioner and in accordance with the "Eight Rights" (i.e., right dose, right drug, right route, right time, right position, right texture, right person, and right documentation).

Administration and Supervision of Psychotropic Medications

Psychotropic medications are appropriate as part of the treatment plan for people who have been diagnosed with a psychiatric illness. Provider agencies must ensure members receiving psychotropic medications have a minimum of quarterly appointments with their treating practitioner and obtain informed consent. Therefore, providers must ensure training is provided on administration of any prescribed psychotropic medications and recognition of side effects, including potentially life-threatening side effects; e.g., neuroleptic malignant syndrome, serotonin syndrome, etc. Involuntary administration of psychotropic medications by provider agency staff is strictly prohibited.

- Psychopharmacology Review Teams have been established in each grand region to provide consultation and recommendations for prescribing clinicians. Contact information is available online: https://www.tn.gov/content/dam/tn/didd/documents/divisions/health-services/Referral_Process_Regional_Psychopharmacology_Review_Team.pdf

Monitoring for Psychotropic Medication Side Effects and Involuntary Movement

It is the responsibility of the practitioner/prescriber of psychotropic medications to ensure that screening for Tardive Dyskinesia ("TD") or medication-induced involuntary movement disorders and monitoring for extrapyramidal side effects is conducted periodically. The interval of TD/medication induced movement disorder screening shall be determined by the practitioner/prescriber, based on his or her clinical judgement and standard of care. It is the responsibility of the provider agency to maintain documentation of the screening (e.g., date and findings) in the service record of the member. Agency staff should report to the

practitioner/prescriber any observed changes in the member, so that the practitioner/prescriber can perform a clinical assessment. It is the responsibility of the provider agency to

Agencies desiring to supplement web-based training may contact the Regional Office EMC of the Protection from Harm Unit for additional classroom training.

Coordination of Benefits

A Coordination of Benefits Protocol is available on TennCare's website, <https://www.tn.gov/tenncare/long-term-services-supports/partners-program-updates/ltss-protocols.html>.

The services for each member are facilitated by an Independent Support Coordinator (ISC) or a DIDD Case Manager (CM), depending upon the 1915(c) Waiver in which the member is enrolled.

The ISC/CM is responsible for ensuring coordination of TennCare and 1915(c) Waiver benefits for all members at every annual Person-Centered Support Plan (PCSP) review. This coordination is also required at multiple points throughout the member's enrollment, including but not limited to, prior to the Member's twenty-first birthday and upon a change in the Member's circumstances. This process requires continuous review and ongoing coordination throughout the member's enrollment to ensure the health and safety of the member and that duplicative services are not being provided. Integral to this process is ensuring the 1915(c) Waiver is the payor of last resort in compliance with the waivers and federal regulations. When the same service is covered through TennCare, non-TennCare other coverage (i.e. private insurance or Medicare), and the 1915(c) Waiver, the TennCare and non-TennCare other coverage benefits shall be utilized first.

The process of coordination and collaboration required in order to monitor services and costs of services provided through the 1915(c) Waiver can be found within the Coordination of Benefits Protocol.

Population Health

Population Health addresses acute health needs or risks which need immediate attention. Assistance provided to individuals is short-term and time limited in nature. Activities may include, but are not limited to, assistance with making appointments, transportation, social services, etc. and should not be confused with activities provided through 1915(c) waiver Independent Support Coordination or DIDD Case Management.

Population Health strives to improve health outcomes by encouraging and promoting the following:

- Relationship with Primary Care Physician (medical home)
- Self-efficacy and self-engagement
- Health and wellness education (diagnosis, risk factors, screenings, preventive care)
- Identification of gaps in care
- Goals and behavior and lifestyle changes
- Medication adherence

Quarterly and annual monitoring to ensure that 1915(c) members receive appropriate Population Health and the adequacy and appropriateness of these interventions based on stratification and setting.

Quality Monitoring for 1915(c)

Amerigroup will collaborate with Department of Intellectual and Developmental Disabilities (DIDD) in its quality monitoring of 1915(c) waiver HCBS. DIDD Quality Monitoring shall include all 1915(c) waiver services as specified in the interagency agreement between TennCare and DIDD.

Quality Management

The contract for federal funding of waiver programs (the approved waiver application) is between CMS and TennCare. TennCare is responsible for administrative oversight of all Medicaid waiver programs. TennCare contracts with DIDD to manage the day-to-day operations involved in making quality waiver services available to eligible people. TennCare performs a number of administrative oversight activities to evaluate DIDD's performance as the operational lead agency and to evaluate DIDD and provider agency compliance with state and federal rules, regulations, and policies.

When DIDD requests documentation to support a response to a TennCare finding, providers are required to provide such documentation to DIDD for TennCare review within ten (10) days or within the timeline prescribed by TennCare. Providers will be required to provide documentation validating that adequate remediation activity has occurred and that corrective actions have been implemented to prevent subsequent related findings. TennCare findings may result in sanctions or recoupments.

Monitoring activities conducted by other state agencies that may involve providers or require the cooperation of providers include:

1. TennCare utilization reviews and audits of services.
2. Audits conducted by the Tennessee Office of the Comptroller to evaluate TennCare's performance in administering the waiver program.
3. Abuse, neglect, and exploitation investigations conducted by the Department of Children Services ("DCS"), Division of Child Protective Services or Department of Human Services ("DHS"), Division of Adult Protective Services ("APS").
4. Regional Financial Reviews conducted by CMS.

The Quality Management System ("QMS") measures quality in terms of achieving outcomes that are important to and important for people. The primary purpose of the QMS is to provide a mechanism for achieving continuous improvement in both the quality of services and the performance of the service delivery system. In addition, the QMS measures compliance with State and federal requirements to ensure ongoing availability of federal funding and provides information that contributes to effective utilization of resources. Quality management is not a static process; there is no beginning or end point. Rather, it is an ongoing circle of measurement, discovery, action/implementation, and re-measurement to determine the effectiveness of strategies employed for improvement of the system.

The following principles guide the QMS:

1. The system must produce improvement(s) in the delivery of services.
2. All tools, processes, and internal operating guidelines developed must be implemented statewide.
3. All tools, processes, and internal operating guidelines developed must be applicable to and effective for all people receiving Medicaid waiver-funded services.
4. The system must include the least amount of duplicative processes as possible.
5. The system must include a database capable of collecting and producing reliable information for analysis and reporting purposes.
6. Reports describing QM activities and trend analysis must be publicly available.
7. The QMS must identify deficiencies and opportunities for improvement.
8. The QMS must highlight positive practices.
9. The QMS must employ targeted interventions and strategies designed to address the causes of identified issues and concerns.

10. The QMS must include effective sanctioning options for serious health and safety issues identified and failure to correct quality and compliance issues in a timely and sustainable way.

QMS Activities and Data Sources

Efficient and effective technology systems are essential to the timely collection and production of performance measure data used to evaluate the system or services and supports. Ongoing analysis of systemic performance is an essential component to continuous Quality Improvement (“QI”). In addition, Quality Management (“QM”) data allows DIDD to assess satisfaction with services, monitor the effectiveness of policy and training initiatives, and ensure adequate fiscal management. Data sources available to the QMS include:

1. New Provider Support Process.
2. Provider Performance Surveys.
3. Individual Waiver-Specific Record Reviews.
4. Fiscal Accountability Review (FAR).
5. Personal Satisfaction Surveys.
6. Event and Investigation (E&I) Data Analysis.
7. Complaint Resolution Tracking.
8. Death Reviews.
9. Provider Self-Assessments.
10. Individual Experience Assessments.

More detailed descriptions of QMS activities are provided in the subsequent sections of this chapter.

Remediation must occur at all levels of the system. Individual findings will require provider and/or DIDD remediation actions. The requirement is to achieve remediation of individual findings within thirty (30) days of discovery. DIDD will perform follow-up validation reviews involving a sample of individual remediation actions. DIDD will complete all remediation actions that are required, this may be as simple as documentation being submitted or as in-depth as on-site technical assistance. Once the validation process is complete DIDD will submit a summary and recommendations to the MCO. Any punitive actions against the provider will be determined and imposed by the MCO.

Provider-level findings will typically require development or revision of a provider QI plan, which specifies strategies for achieving adequate remediation of findings and preventing subsequent related findings. Depending on the nature of the findings, implementation of the provider QI plan may be monitored through follow-up or focused reviews, reassessment during the next scheduled Provider Performance Survey, Regional Provider Support Team (“RPST”) monitoring and technical assistance, or provider submission of documentation supporting QI plan implementation.

Systemic findings will typically require longer time periods to determine the cause of the systemic finding and develop system-wide remediation strategies. Systemic improvement strategies will be proposed by DIDD and discussed with TennCare during monthly QM meetings (if applicable to waiver providers and/or persons). TennCare will monitor implementation of DIDD systemic improvement strategies via review of supporting documentation and data, status updates during interagency meetings, and/or focused surveys. Per CMS requirements, this process may include the development of Quality Improvement Plans by DIDD and TennCare to address specific areas of concern.

It is the provider’s responsibility to develop and implement policies, procedures, and systems congruent with TennCare and CMS regulations, including the HCBS Settings Final Rule. To assist a new provider with these responsibilities, once a newly-approved provider has a fully-executed Provider Agreement, an individual of the RPST will begin to make periodic contacts with the new provider. The primary purpose of this process is to assist

a new provider with administrative areas or program implementation applicable to HCBS regulations and Tennessee State law. RPST involvement in this process will continue at least until the initial Quality Assurance (“QA”) consultative survey and thereafter as determined by the Regional Quality Management Committee (“RQMC”).

As part of the process, the RPST will document its contacts using the New Provider Checklist. For new clinical service providers, the Regional Office clinicians and their Central Office counterparts are available to provide assistance and support, as needed.

Upon the first initiation of services by select 1915(c) waiver providers to one or more 1915(c) waiver members (i.e., the first time the provider begins delivering services in the program), Amerigroup shall notify DIDD of service initiation within ten (10) business days of the initiation of services for purposes of scheduling consultative quality monitoring surveys, as applicable, with DIDD. On completion of the Consultative Survey, providers will be placed on the annual quality monitoring survey schedule.

Provider Performance Surveys are conducted to determine provider outcomes related to Quality Domain Indicators and determine compliance with federally-mandated waiver assurances and related performance measures.

Provider performance is evaluated via the Provider Performance Survey process through outcome measurement in ten (10) quality Domains which are outlined on DIDD’s website.

Survey Tools

Outcomes and Indicators related to each Quality Domain have been incorporated into DIDD Provider Performance Survey Tools. Individual survey tools have been developed for different provider types. Copies of current QA survey tools [1] applicable to specific provider types are available on DIDD website.

Tools include two areas of focus: 1) Evaluation of services and supports received by a sample of member people; and 2) Assessment of the provider’s ability to ensure an adequately trained workforce via review of compliance with requirements of the CMS Qualified Provider assurance, to develop an effective management structure, including a self-assessment process and a QI strategy, and to develop and implement policies and practices that are person-centered and quality-focused. Survey results highlight both exemplary performance and opportunities for improved compliance and/or quality of service.

When appropriate, a focused review is conducted. A focused review is one that gives attention to a particular area that may have created challenges for a provider. During a QA or other review, if it becomes evident that the provider is experiencing difficulty in a given area, (e.g., event management), then the survey may be expanded to include additional review of that area. Systemic findings at the provider level are those that were problematic across several people in the sample or the entire sample. Statewide systemic findings are those that reveal themselves across reviews of a group of providers. When this occurs, it is DIDD’s responsibility to analyze the cause of the systemic finding and work to find strategies that will help the system, as a whole, to improve.

DIDD QA staffs conduct annual surveys of all 1915(c) providers as indicated in the current interagency agreement between TennCare and DIDD. Less frequent surveys may be conducted for provider agencies demonstrating ongoing proficient or exceptional performance in overall operation. When a provider achieves Three- or Four-Star status, DIDD reduces the frequency of monitoring for the next review cycle. There are specific criteria for making decisions about the frequency of monitoring. DIDD may determine that more frequent surveys are necessary to evaluate provider performance in ensuring health, safety, and welfare of

members or to determine resolution of serious compliance issues. Providers achieving Two Star status continue to have annual surveys.

DIDD QA staff conducts initial consultative surveys for new agencies that have initiated service provision but have not previously participated in a Provider Performance Survey. A consultative survey is considered an “informal” survey process intended to give the new provider experience with the survey process and knowledge of compliance issues and needed improvements.

The provider will be required to correct any serious health and safety issues identified during a consultative survey. After the consultative survey is completed, the provider will participate in annual DIDD Provider Performance surveys. Consultative surveys are generally scheduled between ninety (90) days and six (6) months after the agency begins providing services.

A ten percent (10%) representative sample of people will be selected for onsite review during each Provider Performance Survey, with a minimum of four (4) and a maximum of fifteen (15) people selected. The provider will be given a list of people selected for the initial sample on the first day of the survey. Sample size may be increased if issues are identified within the sample population and more information is needed to determine the scope of the issue.

A Provider Performance Survey schedule is developed prior to the beginning of each survey year. Providers will be notified at that time of the approximate date that DIDD plans to begin the agency’s Provider Performance Survey.

For providers serving in more than one region with only one statewide office, QA staff will make arrangements, when possible, to coordinate these reviews.

Approximately sixty (60) days before the start of the survey, DIDD will send written notice to the provider of the actual date the survey will begin. The provider must complete the following activities prior to the survey:

1. Submit required pre-survey information in the required format to DIDD at least thirty (30) days prior to the survey start date.
2. Identify a staff member as DIDD’s contact during the survey process.
3. Notify all persons, involved family members, and legal representatives, as applicable, of the upcoming survey.
4. Notify all persons, involved family members, and legal representatives, as applicable, of the survey team’s availability to discuss the survey processes or services received during the course of the survey.

Providers shall be allowed to determine the best method of distributing information about the survey. Examples of acceptable methods for information distribution include individual correspondence, articles in provider newsletters, announcements posted at service sites, and email announcements.

Surveys begin with a meeting between key provider staff and the survey team. During the initial meeting, participants will discuss the logistics of the survey. The provider may utilize the initial meeting to provide general information about the organization, including management and QI strategies that have been implemented since the last survey. Following the initial meeting, survey activities will begin. Throughout the survey, survey team members will interact with provider staff to ask questions and request needed information. Surveyors will act in accordance with the following during the survey:

1. Initial observations will be considered in light of additional relevant information that is presented or discovered during the course of the survey.

2. Identified issues that are corrected prior to the end of the survey will be included in survey results, with notation of expedient corrective action.
3. Immediate jeopardy issues (that have caused or have potential to imminently cause harm to the person) identified during a survey will require expedient provider corrective action.
4. Internal operating guidelines for reporting will be followed if unreported events are discovered, including notification of DIDD investigators as appropriate.

When survey activities are completed, survey team members will participate in a conciliation process to determine the provider's level of performance based on all information collected and reviewed during the survey. The survey will conclude with an exit conference. During the exit conference, the survey team will review major findings. Please note that participation in an exit conference is beneficial for the provider and provides an opportunity for a review of major findings from the survey. A written final survey report will be provided to the provider as soon as possible following the survey. The final report will also be sent to the provider agency's board chair, or chief officer.

The provider agency shall be held responsible for ensuring that the internal QI plan is revised to address survey findings, as appropriate. In addition, the provider must evaluate self-assessment capabilities and develop QI strategies that allow prompt identification and correction of compliance issues.

If the provider is dissatisfied with the results of the review, a second review may be initiated by submitting a written request to DIDD Commissioner stating the reason a second level review is being requested. The Commissioner or designee will respond to the request as expeditiously as possible, in most cases, within thirty (30) calendar days. Response times will vary depending upon the number and complexity of issues presented with the review request.

All review requests must specify findings to be reviewed and must be accompanied by any documentation available to support requested changes in survey findings. For each step, the provider agency will have ten (10) calendar days from the date of receiving the survey report or written notification of a determination to initiate or continue the review process.

Individual Record Reviews ("IRRs") are conducted during each waiver year to collect data demonstrating compliance for three (3) of the six (6) federally-mandated waiver assurances: Level of Care, Service Plan, and Health and Welfare. IRRs are conducted by DIDD QA staff. DIDD is required to conduct these reviews annually. During each waiver year, a statistically valid random sample of people will be selected for review from each waiver program.

For each person selected, a record review will be conducted by DIDD QA staff utilizing a data collection instrument design based on federally-mandated waiver assurances and CMS-approved performance measures. The current data collection instrument is available on DIDD website.

Designated DIDD Regional Office staff will report findings to the appropriate remediation entities (designated DIDD staff and/or appropriate provider management staff). Appropriate remediation strategies will be implemented. DIDD Regional and Central Office Compliance staff will report findings, remediation activities and remediation timeframes. Remediation actions will be validated by designated DIDD Regional Office staff and by TennCare Long Term Services and Supports staff to ensure successful and timely remediation of findings.

Immediate Jeopardy

Immediate jeopardy issues are those that have caused or have the potential to imminently cause harm to a person. These issues require expedient provider agency corrective action. DIDD will coordinate corrective action with the Amerigroup.

Immediate jeopardy issues include, but are not limited to:

1. Serious medication errors not previously detected or corrected.
2. Lack of follow-up for major medical issues.
3. Failure to follow mealtime staff instructions resulting in choking or imminent risk of choking.
4. Little or no food in the home or little or no food appropriate to a person's special diet.
5. Serious mismanagement of personal funds.
6. Identification of major risk factors in absence of a plan to address the risk.
7. Serious environmental hazards.

When immediate jeopardy is identified, the following actions shall occur:

DIDD, TennCare, or Amerigroup employees identifying the immediate jeopardy situation will contact the agency director or designee to provide verbal notice of the immediate jeopardy situation. DIDD staff will remain on-site as necessary until the immediate jeopardy situation has been resolved sufficiently to ensure the person's health and safety or verify the risk of harm to the person has been removed. DIDD's employee identifying the immediate jeopardy situation or other DIDD staff available will notify DIDD's Regional Office Director or designee of the immediate jeopardy situation and forward a copy of the immediate jeopardy notice when completed. DIDD's employee will issue a written immediate jeopardy notice to the provider describing the situation and time frame by which actions must be taken to ensure the person's health and safety. DIDD's employee will send a copy of the immediate jeopardy notice to the person's ISC/CM. DIDD's employee will assure that a REF is completed, and the Investigations Unit is notified of the situation. The provider will notify the person's legal representatives and/or involved family members. If necessary, designated DIDD staff will validate and document corrective actions taken. Survey scores and ratings may be affected by immediate jeopardy findings during a survey, even when timely corrections are implemented.

Satisfaction Surveys

Personal satisfaction surveys provide information about the quality of services and supports directly from the people who receive them. The person's perspective is a valued and essential component of the QMS. The person and/or family member interviews are utilized to obtain information about the impact of services and supports on quality of life during Provider Performance surveys and/or other monitoring processes. Provider agencies are required to conduct personal survey and use the information obtained to improve the quality of services and supports. For support coordination agencies, evaluation of personal satisfaction with independent support coordination services occurs with completion of the Support Coordination Monthly Documentation Form, which can be found on DIDD's website. Other provider agencies are required to conduct an annual survey, the results of which are reviewed during DIDD Provider Performance Surveys. Development of the satisfaction survey is the agency's responsibility.

DIDD contracts with an external entity to administer the annual People Talking to People ("PTP") Survey. The current PTP survey format is available on DIDD's website. The PTP survey involves face-to-face interviews with persons and/or family members conducted by an independent evaluator employed by the contractor. The contractor works with DIDD PTP Director to collect and analyze survey data and produce an annual PTP Survey Report. Trends are reported statewide, by region, and by waiver program. PTP Survey data is utilized to document compliance with CMS-approved performance measures related to the Service Planning and Health and Welfare federally-mandated waiver assurances. PTP data is also used to identify systemic issues and develop systemic QI strategies.

Both complaint data and event and investigations data are utilized to monitor compliance with the federally-mandated health and welfare assurance and related CMS-approved performance measures. Information on incidents and investigations is used to determine if more frequent provider monitoring or provider technical assistance is warranted.

Complaints are handled by the Customer Focused Service Coordinators in the regions of the state. Providers are required to establish a complaint resolution process to address complaints submitted by members and families. Providers are also required to have an identified complaint contact person and to maintain documentation of all complaints filed.

Event and Investigation data is maintained by DIDD Reportable Event Management Team, which produce the following information:

1. Types and numbers of incidents statewide, by region, by waiver and by provider.
2. Number of investigations completed statewide, by region, by waiver and by provider.
3. Rates of substantiated investigations statewide, by region, by waiver and by provider.
4. Death reviews are conducted by DIDD Regional Death Review Committees for all unexpected and unexplained deaths. DIDD policy 90.1.2 Death Reporting and Comprehensive Death Review is available on DIDD website.

Each region maintains a Regional Quality Management Committee (“RQMC”) comprised of management level staff of all units within the region. This group meets on a regular basis, at least monthly, to review provider performance and determine the need and frequency of RPST follow-up. Results of each QA Provider Performance survey are reviewed along with information from other components of the QMS, such as complaint information, I&I information, RPST follow-up information, etc. Based on review of provider performance or other issues, follow-up actions are planned if warranted.

The Statewide Quality Management Committee (“SQMC”) is comprised of management level staff of all units within the Central Office and includes representation from each Regional Office. This group meets monthly and reviews statewide data to determine trends and initiate follow-up actions if warranted. Additionally, information as to actions taken by the RQMC in response to specific provider performance or other issues is reported to the SQMC, which ensures statewide consistency and maintains oversight of regional QM activities. Amerigroup will participate in the monthly RQMC and SQMC meetings when surveys are reviewed, and recommendations are made to Amerigroup regarding what actions should be taken. If the issue identified affects multiple members supported, Amerigroup and DIDD PST will complete the necessary follow-up which may include technical assistance. Upon completion of the follow-up DIDD PST will send a summary including recommendations for any follow-up actions from Amerigroup. Any punitive actions against the provider such as sanctions will be determined and imposed by Amerigroup, after consultation with DIDD.

The Regional Provider Support Teams (“RPSTs”) consist of Regional Office staff persons within the Operations Unit of each region. A primary focus of the RPST is to support new contractors with DIDD. The RPST also supports existing providers performing below acceptable standards in QA Domain 2 (Individual Planning and Implementation), Domain 3 (Safety and Security), Domain 5 (Health) and/or Domain 9 (Provider Capabilities and Qualifications). New providers will be assisted in all domains. Activities of the RPST are reported regularly to the RQMC.

Technical Assistance

Technical Assistance (“TA”) may be requested by the provider or mandated by DIDD. DIDD TA is provided by RPST individuals or by ad hoc teams formed to provide specialized TA.

As previously stated, it is the provider’s responsibility to develop and implement policies, procedures, and systems congruent with TennCare and CMS regulations. The primary focus of Regional Office involvement with this process is to assist the provider in understanding the interpretations and expectations of TennCare and CMS. TA may involve help with identifying causative factors, identifying resources available to the provider, developing internal strategies for correction of systemic issues, and/or measuring improvements achieved with implementation of corrective actions.

Request for Technical Assistance (“RTA”)

A Request for Technical Assistance (RTA) may be submitted to the Regional Office Director of Operations for providers of Day, Residential, Personal Assistance, or Independent Support Coordination services or to the Regional Clinical Director for the appropriate clinical discipline. Every effort will be made to respond to RTAs in a timely manner.

Mandated Technical Assistance (“MTA”)

Mandated Technical Assistance (MTA) may be required when there is a pattern of failure to ensure the health, safety, and welfare of members. Situations that may result in MTA include, but are not limited to:

1. Identification of immediate jeopardy issues that are significant in terms of scope, frequency or severity.
2. An overall performance rating of “Serious Deficiencies” or “Significant Concerns” as determined through a QA Provider Performance Survey.⁶
3. QA Provider Performance Surveys identifying minimal or non-compliance in Individual Planning and Implementation (Domain 2), areas related to safety and security (Domain 3), health (Domain 5) or Provider Capabilities/Qualifications (Domain 9).
4. QA Provider Performance surveys identifying repeat findings that have not been adequately resolved or have not been adequately addressed through ongoing QI strategies.
5. A Provisional license is issued by DIDD, DOH, or any other licensure entity.
6. Financial issues are identified that threaten the continued financial viability of the agency.
7. Other serious issues identified through any monitoring activity that are equivalent to those listed above in terms of effect on persons served or ability to operate as a provider agency.

All Technical Assistance and recommendations will be shared with Amerigroup by DIDD as will information and results of any consultations.

⁶ For additional information on how performance is scored, go to DIDD’s web site, Quality Management page, Survey Tools, Annual Quality Assurance Survey Report Card.

Notification

The provider Executive Director shall be notified in writing by the Regional Office Director or designee of the performance issues for which MTA is being imposed.

A copy of the letter shall be sent to the Board Chair (if a non-profit organization) and to the corporate office if out of state. The notification will include information about the provider's right to appeal a sanction as required by Title 33 of the TCA.

Notification will continue to be sent by the Regional Office Director on behalf of SQMC and will include Amerigroup. Providers will have the choice to either accept MTA from the Regional Office or another external entity chosen.

Selection of an Entity to Provide Technical Assistance

The provider may accept MTA from DIDD at no cost. The provider also may choose to contract with an outside entity that is approved by DIDD, at the provider's expense.

1. Within ten (10) days of notification of MTA, providers must notify the Regional Office of their choice to accept MTA from DIDD or the external entity chosen.
2. If the provider selected is presently contracted with DIDD, they must have performed in the substantial compliance range in the Domains for which they are providing the TA.
3. Information as to the provider's selection will be reported to the SQMC at the next regularly scheduled meeting of the SQMC.
4. When a provider chooses an external TA provider, the RPST will continue to make monitoring visits to assess the progress of a provider on a schedule determined by the RQMC.
5. RQMC reserves the right to require that a provider choose an external source for TA if the provider has previously had MTA and not maintained improvements or if sufficient progress has not been made over time.
6. RQMC reserves the right to rescind approval of the external TA provider based on lack of progress over time or change in performance of the external technical assistance provider.

External Technical Assistance

1. An initial meeting will occur with both providers prior to the start of the TA. Whenever possible, a member of the RPST will be in attendance. A written Technical Assistance agreement, as well as a business agreement addressing HIPAA requirements, will be signed.
2. The provider that will receive TA will submit to the RPST Coordinator the external TA provider's plan for assisting the agency to achieve compliance and the indicators or measures the provider will use to track progress in achieving compliance.
3. The RQMC may accept or reject all or part of the TA plan developed by the external TA provider. If all or part of the plan is rejected, the provider will be notified of revisions needed for the plan to be acceptable.
4. The provider will report data monthly to the RPST Coordinator to demonstrate its ongoing efforts and progress toward achieving compliance.

DIDD Mandated Technical Assistance ("MTA")

1. If DIDD is chosen to provide the TA, the provider shall be contacted by RPST staff to schedule the initial meeting. A written TA agreement will be signed at the initial meeting.
2. A period of thirty (30) calendar days will be allowed for the RPST and provider to work together to identify the cause(s) of noncompliance issue(s) and begin to develop and finalize a measurable MTA Systemic Corrective Action Plan (S-CAP) plan, and set timeframes for completion.

- MTA Systemic Corrective Action Plan (S-CAP): A subset of the agency’s quality improvement plan that is developed in collaboration with the RPST once a provider is placed on MTA. This document outlines specific findings, the providers plan for correcting them, monthly status updates from the provider, and any RPST feedback.
 - The S-CAP, once completed, will be reviewed by both DIDD and the Amerigroup, who will work together to set the timeframes for completion.
1. The provider will finalize and submit the S-CAP to the Provider Support Team Lead within thirty (30) calendar days, ensuring that all indicators for which MTA is imposed are addressed.
 2. By the tenth (10th) of the month, unless otherwise determined by the RQMC, the provider will submit self-assessment data to the RPST specific to progress toward compliance on the S-CAP.
 3. During the next ninety (90) calendar days the provider will continue to work in collaboration with the RPST on MTA. The RPST will utilize various TA techniques, such as process mapping, side-by-side assessment, training on specific topics, etc.
 4. A validation review will be scheduled to assess the provider’s progress within ninety (90) calendar days of acceptance of the S-CAP. A validation tool will be utilized and consist of a subset of essential quality indicators from the QA Survey Tool; and will be customized to the provider based on the performance issues which have resulted in MTA. The validation tool is individually designed for the provider requiring TA. It consists only of outcomes and indicators and interpretive guidance taken from the QA Survey Tool. It is not a new QA tool or checklist.
 5. If the provider is making progress, but needs additional time to achieve compliance, the RQMC may make a recommendation to the SQMC for an extension of ninety (90) calendar days. Upon approval by the SQMC for the extension, the provider will be notified in writing.
 6. If there are extenuating circumstances after the first 90-day extension; e.g., change in director or senior management, natural disasters (fire, tornado), etc.; and compliance is still not achieved, SQMC may authorize an additional 90-day extension, prior to the imposition of benchmarks.
 7. If the provider is not making progress, the RQMC may recommend to the SQMC that further administrative actions, up to and including termination of Provider Agreement, may be taken.

Conclusion of Technical Assistance

TA will be concluded when the provider has achieved compliance with the outcomes described in the QI Plan and SQMC has given approval. Progress in meeting TA goals will be evaluated based on provider performance presented to the RQMC. A letter will be sent to the Executive Director and Board Chair (if applicable) to notify them of the conclusion of MTA. An evaluation of the MTA process will be attached for feedback to be sent to the Regional Office Director.

Electronic Visit Verification (EVV) System

The EVV system is an electronic system used to monitor a Member’s receipt and utilization of certain services. 1915(c) Waiver providers will continue to utilize DIDD’s current EVV vendor. DIDD will administer and monitor 1915(c) Waiver provider's EVV Compliance.

Billing and Claims Submission

Upon implementation of the IDD Integration, Amerigroup will be responsible for the payment of all LTSS services provided to members with I/DD, including HCBS provided to members enrolled in 1915(c) waivers.

Claim Submissions for 1915(c) Waiver services will continue to be submitted to DIDD per the Protocol. Amerigroup will pay these claims as outlined in the claim’s adjudication process.

Claims Status

For information on provider claims submissions or payment disputes, providers should contact the Office of Business at DIDD via Services-DIDD_billing.ACR@tn.gov.

Cost-Sharing and Patient Liability

Providers shall not require any cost-sharing or patient liability responsibilities for covered services, except to the extent that cost-sharing or patient liability responsibilities are required for those services by TennCare rules and regulations, including holding members liable for debt due to insolvency of Amerigroup or nonpayment by the state to Amerigroup. Further, providers shall not charge members for missed appointments.

Patient Liability

TennCare will notify Amerigroup of any applicable patient liability amounts for I/DD MLTSS Programs via the eligibility/enrollment file. Members owing a patient liability will pay that amount to Amerigroup. If the effective date is any time other than the first day of the month, Amerigroup shall determine and apply the pro-rated portion of patient liability for that month.

For 1915(c) waiver members, patient liability shall be collected as follows.

Amerigroup delegates collection of patient liability for 1915(c) waiver members who reside in a CBRA (i.e., an assisted care living facility, a home where the member receives community living supports or community living supports-family model, adult care home as licensed under 68-11-201, or any of the residential services provided under the Section 1915(c) waivers) to the CBRA provider and shall pay the provider net of the applicable patient liability amount.

Amerigroup will collect patient liability from 1915(c) waiver members (as applicable) who receive 1915(c) waiver HCBS in his/her own home, including members who are receiving short-term nursing facility care.

Amerigroup will use calculated patient liability amounts to offset the cost 1915(c) waiver benefits (or CEA services provided as an alternative to covered 1915(c) waiver benefits) reimbursed by the CONTRACTOR for that month.

Amerigroup will not collect patient liability that exceeds the cost of 1915(c) waiver benefits (or CEA services provided as an alternative to 1915(c) waiver benefits) reimbursed by Amerigroup for that month.

If a 1915(c) waiver member fails to pay required patient liability, pursuant to CRA Sections A.2.6.1.5.7.6, A.2.6.1.6.13, and A.2.6.1.7.12, Amerigroup may request to no longer provide long-term services and supports to the member.

Amerigroup will not waive or otherwise fail to establish and maintain processes for collection of patient liability in accordance with the CRA.

Preventive Services

TennCare cost-sharing or patient liability responsibilities apply to covered services other than the preventive services described in TennCare rules and regulations.

Provider Requirements

Providers or collection agencies acting on the provider's behalf may not bill members for amounts other than applicable TennCare cost-sharing or patient liability amounts for covered services, including services that the

state or Amerigroup has not paid for, except as permitted by TennCare rules and regulations and as described below.

Providers may seek payment from an enrollee only in the following situations:

- If the services are not covered services and, prior to providing the services, the provider informed the member that the services were not covered
 - The provider will inform the enrollee of the noncovered service and have the enrollee acknowledge the information. If the member still requests the service, the provider will obtain such acknowledgment in writing prior to rendering the service; regardless of any understanding worked out between the provider and the member about private payment. Once the provider bills Amerigroup for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the member.
- If the member's TennCare eligibility is pending at the time services are provided and if the provider informs the person, he or she will not accept TennCare assignment whether eligibility is established retroactively
 - Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Amerigroup for the service, the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.
- If the Member's TennCare eligibility is pending at the time services are provided; however, all monies are collected, except applicable TennCare cost sharing or patient liability amounts, shall be refunded when a claim is submitted to Amerigroup because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established
 - The monies collected will be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim.
- If the services are not covered because they are in excess of an enrollee's benefit limit, and the provider complies with applicable TennCare rules and regulations.

Providers must accept the amount paid by Amerigroup or appropriate denial made by Amerigroup (or, if applicable, payment by Amerigroup that is supplementary to the Individual's third-party payer) plus any applicable amount of TennCare cost-sharing or patient liability responsibilities due from the member as payment in full for the service. Except in the circumstances described above, if Amerigroup is aware that a provider or a collection agency acting on the provider's behalf bills a member for amounts other than the applicable amount of TennCare cost-sharing or patient liability responsibilities due from the enrollee, we will notify the provider and demand that the provider and/or collection agency cease such action against the member immediately. If a provider continues to bill a member after notification by Amerigroup, we will refer the provider to the Tennessee Bureau of Investigation.

Provider Grievance and Appeals

Providers may access the Amerigroup Medicaid Provider Manual via the Amerigroup provider portal, <https://provider.amerigroup.com/tennessee-provider/home> > Resources> Policies, Guidelines and Manuals> Provider Manual (Medicaid). Amerigroup's Provider Complaint Procedures are outlined within the Amerigroup Provider Manual for Medicaid Services.

Provider Responsibilities for Complaint Resolution⁷

Providers are required to establish a complaint resolution process to address complaints submitted by members or their families. Providers are also required to have an identified complaint contact person and to maintain

documentation of all complaints filed. DIDD has a Complaints Coordinator at each Regional Office who assists with complaint resolution. Complaints are monitored via a DIDD database to ensure timely and satisfactory resolution.

By virtue of being a licensee under TCA § 33-2-402 and in accordance with the Provider Agreement, providers are required to adhere to Section 84.7 of the Rehabilitation Act of 1973 and develop written policies that describe how the providers will resolve complaints and other issues relative to the provision of services. Providers are required to ensure that information about such policies has been provided to members or their legal representative(s). Providers are required to implement complaint resolution processes to ensure that complaints are recorded, and action(s) taken for resolution is/are documented. The provider's complaint resolution system must include but is not limited to:

1. Designation of a staff member as the complaint contact person.
2. Maintenance of a complaint contact log.
3. Documentation and trending of complaint activity.

Complaint contact logs shall include the following:

1. Date complaint received.
2. Contact information.
3. Name of complainant.
4. Name of member.
5. Agency and ISC involved.
6. Description of complaint.
7. Description of Resolution (complainant confirmed).
8. Date of Resolution.

Upon admission providers must notify each member, family member(s), or legal representative, as applicable, of the provider's complaint resolution system and DIDD's Complaint Resolution System, its purpose, and the steps involved to access it. This information will identify both the provider and DIDD contact and their contact information. Providers must inform members or their legal representative(s) that filing a complaint does not void their right to request a fair hearing, nor is it a prerequisite for a fair hearing.

Providers must attempt to resolve all complaints within thirty (30) calendar days of the date that the complaint was filed. If a resolution cannot be achieved between the provider and the complainant, a formal complaint will be filed with DIDD Customer-Focused Services ("CFS") Unit or other DIDD representatives. The provider will provide the complainant with DIDD CFS Unit contact information. Upon being contacted, the CFS Unit will engage DIDD's Complaint Resolution System³ for addressing unresolved issues regarding the quality of service and supports.

Provider Responsibilities Related to Eligibility Appeals

Eligibility appeals are related to initial or continuation of eligibility to receive waiver services.

ISCs and CMs are required to assist applicants/individuals in appealing eligibility denials or terminations of eligibility as necessary. This may involve explaining any denial notices received, explaining the appeals process, assisting the applicant/individual in submission of a timely appeal request, assisting the applicant/individual in preparing for the appeal hearing, assisting in making arrangements for a telephone or "in-person" hearing, assisting the applicant/individual in obtaining legal representation, and/or providing testimony regarding needs

⁷ Reference DIDD policy 10.2.8 Complaint Resolution System

<https://www.tn.gov/content/dam/tn/didd/documents/policies/10/10.2.8%20-%20Complaint%20Resolution.pdf>

and capabilities during an appeal hearing. Other providers may be required to provide records, information, or hearing testimony that allows the judge to determine if eligibility criteria or requirements are met. Service appeals are related to the ability to receive a particular service within a program that may offer a variety of different service options.

The Grier Order was the result of a class action lawsuit called Grier vs. Wadley. The Grier order outlined requirements which ensured adequate compliance and procedural protection upon the denial of Medicaid services to an eligible person. This Order was vacated on June 17, 2015; however, many of the compliance and procedural protections continue to be in effect per TennCare, state and federal rules.

In accordance with the TennCare Rules, a person enrolled in the waiver program may appeal an “adverse action” regarding Medicaid benefits or services. An adverse action refers to a delay, denial, reduction, suspension, or termination of Medicaid benefits or services, as well as any acts or omissions which impair the quality, timeliness, or availability of such benefits or services. If needed, the ISC/CM or the provider may support the member in filing an appeal.

The TennCare rules contain specific appeal rights, notice requirements, procedural guidelines, and compliance requirements to ensure that every denial of a Medicaid benefit or service is processed in the same manner.

Request to Terminate Services

1915(c) waiver providers are required to provide notice of at least sixty (60) days in advance of the proposed date of service termination to Amerigroup, the ISC and/or DIDD Case Manager when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the Member’s Independent Support Coordinator or DIDD Case Manager to facilitate a seamless transition to alternate providers.

When a 1915(c) waiver HCBS provider change is initiated for a member, a provider must, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the Member’s person-centered support plan, as appropriate until the member has been transitioned to a new provider, as determined by Amerigroup, the ISC and/or DIDD Case Manager, or as otherwise directed by Amerigroup, the ISC and/or DIDD Case Manager, which may exceed sixty (60) days from the date of notice to Amerigroup unless the member refuses continuation of services, the Member’s health and welfare would be otherwise at risk by remaining with the current provider or if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm. Amerigroup shall document clearly any member refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the member and/or the staff will result in services not being delivered. Prior to discontinuing service to the member or prior to Provider termination of its Provider Agreement, as applicable, the

Provider will be required to:

- Provide a written notification of the planned service discontinuation to the member, his/her conservator or guardian, and his/her support coordinator, no less than sixty (60) days prior to the proposed date of service or Provider Agreement termination;
- Obtain Amerigroup, the ISC and/or DIDD Case Manager’s approval in the form of a signed PCSP, to discontinue the service and cooperate with transition to any subsequent, authorized service provider as is necessary; and
- Consult and cooperate with Amerigroup, the ISC and/or DIDD Case Manager in the preparation of a discharge plan for all members receiving care and service from the Provider in the event of a proposed termination of service. Also, when appropriate, as part of the discharge plan, the terminating provider

shall meet, consult and cooperate with any new providers to ensure continuity of care and as smooth a transition as possible.

- Specify that reimbursement of 1915(c) waiver HCBS provider shall be contingent upon the provision of services to an eligible member in accordance with applicable federal and state requirements and the Member's plan of care or person-centered support plan, as appropriate as authorized by DIDD, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the member receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other caregivers (whether paid or unpaid) regarding the member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service – electronic visit verification that fully comports with the 21st Century Cures Act and TENNCARE requirements shall be deemed sufficient to meet this requirement;
- Require 1915(c) waiver HCBS providers, as applicable, to use the electronic visit verification system specified by DIDD in accordance with DIDD requirements
- Require that upon acceptance by the 1915(c) waiver HCBS provider to provide approved services to a member as indicated in the Member's person-centered support plan, as appropriate, the provider shall ensure that it has staff sufficient to provide the service(s) authorized by DIDD in accordance with the Member's person-centered support plan, as appropriate, including the amount, frequency, duration and scope of each service in accordance with the Member's service schedule as applicable;
- Require 1915(c) waiver HCBS providers to provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service;

**INTERMEDIATE CARE FACILITIES/INDIVIDUALS WITH
INTELLECTUAL DISABILITIES (ICF/IID)**

INTRODUCTION

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A licensed facility approved for Medicaid reimbursement that provides specialized services for members with ID and that complies with current federal standards and certification requirements set forth in 42 C.F.R., Part 483.

Upon implementation of the I/DD integration, Amerigroup will be responsible for services in an Intermediate Care Facility for Members with Intellectual Disabilities (ICF/IID).

Members residing in an Intermediate Care Facility will have an Individual Program Plan (IPP) (42 CFR 483.440(c)) developed by the facility's interdisciplinary team, which includes opportunities for individual choice and self-management and identifies the discrete, measurable, criteria-based objectives the member is to achieve; and the specific individualized program of specialized and generic strategies, supports, and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the member to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

Community Informed Choice

Amerigroup will work with ICF/IID providers to coordinate the care of other covered services for members residing in an ICF/IID. For members residing in an ICF/IID, this includes covered services that are not included in the per diem reimbursement for institutional services (e.g., inpatient and outpatient care, certain items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation). For dual eligible members, Medicare shall be the primary payer except as provided below for NEMT.

Prior to approval of Medicaid Reimbursement or admission to an ICF/IID, a person must complete the Community Informed Choice process. The Community Informed Choice process allows a person the opportunity to explore all options available to them in the community and to receive services in the most integrated setting appropriate, in accordance with Federal Law. The Community Informed Choice process is conducted by an entity other than the ICF/IID provider to ensure that she/he fully understands the full array of community-based options available to meet his/her needs, having been fully informed, affirmatively chooses the institutional placement.

Amerigroup is responsible for providing the following care coordination to members receiving services in an ICF/IID:

- Coordinate with the ICF/IID as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the Member's acute and/or chronic health conditions, including services covered by Amerigroup that are beyond the scope of the ICF/IID services benefit;
- Intervene and address issues as they arise regarding payment of patient liability in order to avoid the consequences of non-payment;
- In the manner prescribed by TENNCARE and in accordance with this Agreement and TENNCARE policies and protocols pertaining thereto: 1) facilitate transfers between ICFs/IID which, at a minimum, includes notification to the receiving facility of the PAE Submission with a level of care (LOC) determination, and notification to TENNCARE; and 2) facilitate transitions to CHOICES which shall include (but is not limited to) timely notification to TENNCARE; and
- At a minimum, Amerigroup considers the following a potential significant change in needs or circumstances for members residing in an ICF/IID and contact the ICF/IID to determine if a visit and reassessment is needed:

- Pattern of recurring falls
- Incident, injury or complaint
- Report of abuse or neglect
- Frequent hospitalizations
- Frequent emergency department utilization; or
- Prolonged or significant change in health and/or functional status

SCREENING

The Community Informed Choice (CIC) is the process in which an applicant to an ICF/IID must participate prior to approval for Medicaid reimbursement in an ICF/IID to ensure opportunity to receive services in the most integrated setting appropriate, in accordance with federal law. The CIC process is conducted by an entity other than the ICF/IID provider to ensure that the member fully understand the full array of community-based options available to meet the Member’s needs, and having been fully informed, affirmatively chooses the institutional placement.

Amerigroup will use the TennCare Preadmission Evaluation (PAE) Tracking System, the system of record for I/DD MLTSS Programs level of care determinations, to facilitate submission of all PAEs. (I.e. level of care) applications, including required documentation pertaining thereto, and to facilitate enrollments into and transitions between LTSS programs, including CHOICES and I/DD MLTSS Programs. All data entry, tracking processes and timelines established by TENNCARE can be found in a policy or protocol, Community Informed Choice (CIC) for ICF/IID, housed on the TennCare LTSS Protocol webpage.

COORDINATION OF BENEFITS FOR ICF/IID

Amerigroup will ensure continuity and coordination among physical health, behavioral health, and ICF/IID Providers. For ICF/IID Providers, the Member’s Support Coordinator, as applicable, shall ensure continuity and coordination of physical health, behavioral health, and ICF/IID services and facilitate communication and ensure collaboration among physical health, behavioral health, and ICF/IID Providers.

Amerigroup will coordinate the provision of covered services with services provided by ICF/IID and 1915(c) waiver providers to minimize disruption and duplication of services.

REIMBURSEMENT FOR ICF/IID

Reimbursement for ICF/IID services will be subject to the following limitations:

1. Days when a member receives care in an ICF/IID, and such days have not been approved by Medicaid for payment of his/her care in the facility are not eligible for Medicaid reimbursement; and
2. Reimbursement for bed holds shall be made as follows with payments for days in excess of these limits not eligible for Medicaid reimbursement:
3. For days not to exceed fifteen (15) days per occasion while the member is hospitalized, and the following conditions are met:
4. The member intends to return to the ICF/IID;
5. The hospital provides a discharge plan for the member;
6. At least eighty percent (85%) of all other beds in the ICF/IID certified at the Member’s designated level of care (i.e. intensive training, high personal care or medical), when computed separately, are occupied at the time of hospital admission; and
7. Each period of hospitalization must be physician ordered and documented in the Member’s medical record in the ICF/IID;

8. For days not to exceed sixty (60) days per state fiscal year and limited to fourteen (14) days per occasion while the member, pursuant to physician's order, is absent from the facility on a therapeutic home visit or other therapeutic absence. In order to be eligible for reimbursement, therapeutic home visits or therapeutic absences from the facility (i.e., for purposes other than required hospitalizations, which cannot be anticipated) must be included in the Member's plan of care.

ICF/IID providers are required to promptly notify Amerigroup when a person is discharged from the facility.

BILLING AND CLAIMS SUBMISSION

Electronic Submission

Upon implementation of the IDD Integration, Amerigroup will be responsible for the payment of all LTSS services provided to members with I/DD, including services provided to members in an ICF/IID.

ICF/IID providers will continue to submit billing in the current manner they do today into the DIDD claiming system. Amerigroup will pay these claims as outlined in the claim's adjudication process.

GRIEVANCE AND APPEALS

A person who is enrolled in the HCBS waiver has the right to file an appeal in cases of denial of eligibility or denial of waiver-funded services. This includes fair hearing and due process rights. Provider responsibilities related to eligibility, service appeals, and maintaining compliance with TennCare and federal requirements as described below.

Provider Responsibilities Related to Eligibility Appeals

Eligibility appeals are related to initial or continuation of eligibility to receive waiver services. ISCs and CMs are required to assist applicants/members in appealing eligibility denials or terminations of eligibility as necessary. This may involve explaining any denial notices received, explaining the appeals process, assisting the applicant/member in submission of a timely appeal request, assisting the applicant/member in preparing for the appeal hearing, assisting in making arrangements for a telephone or "in-person" hearing, assisting the applicant/member in obtaining legal representation, and/or providing testimony regarding needs and capabilities during an appeal hearing. Other providers may be required to provide records, information, or hearing testimony that allows the judge to determine if eligibility criteria or requirements are met.

Provider Responsibilities Related to Service Appeals

Service appeals are related to the ability to receive a particular service within a program that may offer a variety of different service options.

The Grier Order was the result of a class action lawsuit called Grier vs. Wadley. The Grier order outlined requirements which ensured adequate compliance and procedural protection upon the denial of Medicaid services to an eligible person. This Order was vacated on June 17, 2015; however, many of the compliance and procedural protections continue to be in effect per TennCare, state and federal rules.

In accordance with the TennCare Rules, a person enrolled in the waiver program may appeal an "adverse action" regarding Medicaid benefits or services. An adverse action refers to a delay, denial, reduction, suspension, or termination of Medicaid benefits or services, as well as any acts or omissions which impair the quality, timeliness, or availability of such benefits or services. If needed, the ISC/CM or the provider may support the person in filing an appeal.

The TennCare rules contain specific appeal rights, notice requirements, procedural guidelines, and compliance requirements to ensure that every denial of a Medicaid benefit or service is processed in the same manner.

Provider Responsibilities in Maintaining TennCare Compliance

Providers have the responsibility to maintain compliance requirements as defined in the TennCare rules.

Provider responsibilities include, but are not limited to:

1. Ensuring that services are provided in full as authorized in the Plan of Care (i.e., Individual Program Plan).
2. Services must be provided consistently and timely, ensuring that there are no gaps in service delivery. There must not be any act or omission which would impair the quality, timeliness, or availability of authorized services. Failure to provide services in accordance with these requirements may result in sanctions or recoupment of funds by DIDD.
3. Providing all accurate and relevant information upon service request submissions and responding promptly and completely to the local Regional Office requests for clarification or additional information regarding service requests.
4. Providing documentation and information as necessary to DIDD or TennCare staff to ensure timely resolution of appeals.
5. Ensuring that appropriate staff are educated on TennCare rules, specifically on its compliance requirements in relation to the Medicaid waiver. At a minimum, appropriate staff are those who are directly or indirectly involved in ensuring that services are provided consistently and timely, are responsible for scheduling and employing direct care staff, are responsible for health care management and oversight, and/or involved in obtaining service authorizations.

Individual Program Plan

Individual Program Plan (IPP) (42 CFR 483.440(c)) is the plan for members with intellectual disabilities in intermediate care facilities, developed by the facility's interdisciplinary team, which includes opportunities for individual choice and self-management and identifies: the discrete, measurable, criteria-based objectives the member is to achieve; and the specific individualized program of specialized and generic strategies, supports, and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the member to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status. ICF/IID providers must provide individualized health and related services as well as active treatment services as prescribed in federal regulation and in accordance with each member's individual program plan, and to coordinate with Amerigroup as needed to facilitate timely access to medically necessary services beyond the scope of the ICF/IID benefit.

Utilization Review Plan

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) must establish and implement an approved utilization review plan in accordance with state and federal regulations. The plan must be written, provide for a review of the necessity to stay at least every six months or more frequently if indicated at the time of assessment, submitted to Amerigroup for review and approval, and monitored by Amerigroup on an ongoing basis to ensure that it is implemented and that utilization of ICF/IID services continues to be appropriate for each of Amerigroup's members served in the facility.

Contact Information

For Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), please call Amerigroup Provider Services at **866-840-4991** for precertification/notification, health plan network information, member eligibility, claims information, inquiries and recommendations you may have about improving our processes and

managed care program. Live Provider Services representatives are available Monday-Friday from 8 a.m.-5 p.m. Central time. You may also use our automated Provider Inquiry Line (IVR) 24 hours a day, 7 days a week, to:

- Check claims status and eligibility.
- Request interpreter services.

Members enrolled in ECF CHOICES and ICF/IID facilities can call Amerigroup Member Services at 1-866-840-4991 (TTY 711) to speak to a live agent Monday-Friday from 7 a.m. to 7 p.m. Central time. Members can also contact the 24-hour Nurse Helpline for:

- Around-the-clock clinical services.
- Assistance with coordinating behavioral health care needs.

Patient Liability in an ICF/IID

Amerigroup will delegate collection of patient liability for members receiving ICF/IID services to the ICF/IID and will pay the facility net of the applicable patient liability amount.

In accordance with the involuntary discharge process, including notice and appeal (see CRA Section A.2.12.10.3), an ICF/IID may refuse to continue providing services to a member who fails to pay his or her patient liability and for whom the ICF/IID can demonstrate to the Amerigroup that it has made a good faith effort to collect payment.

If Amerigroup is notified that an ICF/IID is considering discharging a member (see CRA Section A.2.12.10.3), Amerigroup will work to find an alternate ICF/IID willing to serve the member and document its efforts in the Member's files.

**ALL 1915(c), EMPLOYMENT AND COMMUNITY FIRST (ECF)
CHOICES AND INTERMEDIATE CARE FACILITY FOR
INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)**

CONTRACTING, CREDENTIALING AND RECREDENTIALING

Upon implementation of the I/DD Integration, Amerigroup will partner with DIDD to develop and implement a consolidated process for credentialing and recredentialing long-term services and supports providers, including I/DD MLTSS Programs, that seeks to minimize provider burden resulting from duplicative review processes when a provider is contracted with more than one MCO. The consolidated process will, as applicable, meet the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs and ensure that all long-term services and supports providers, including those credentialed/recruited in accordance with NCQA Standards and Guidelines for the Accreditation of MCOs, meet applicable State requirements, as specified by TENNCARE in State Rule, the Contractor Risk Agreement, or in policies or protocols.

Upon implementation of the I/DD Integration until notification from DIDD is received, DIDD will credential all new I/DD MLTSS providers and recredentialing for all ECF CHOICES and ICF/IID providers will be completed by Amerigroup.

Beginning on or after July 1, 2022, as directed by TennCare (which may vary by service type), Amerigroup may contract with any ICF/IID provider or 1915(c) waiver provider credentialed (or re-credentialed) by DIDD as meeting qualifications for the delivery of specified services, while ensuring Amerigroup will have an adequate network to initiate and consistently deliver services in accordance with each Member's PCSP or IPP. This will include Support Coordination services for members enrolled in the Statewide or CAC Waivers. (Support Coordination functions for members in the Self-Determination Waiver shall be performed by DIDD Case Managers.)

Amerigroup will also take into consideration any preferred contracting standards or quality performance indicators adopted by TENNCARE and DIDD, while ensuring an adequate network of providers who are qualified to deliver high quality services, including the achievement of member and system outcomes. Amerigroup will coordinate with TennCare, DIDD, providers and other stakeholders to define and refine these standards on an ongoing basis and will support contracted providers in building capacity to deliver high quality services, including the achievement of member and system outcomes.

Amerigroup will 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.

Ongoing MLTSS Program HCBS Providers must be recruited annually. All other ECF CHOICES and 1915(c) Waiver HCBS providers (e.g., pest and assistive technology) must be recruited at a minimum every three years but will have an annual site visit. Per TennCare at a minimum, credentialing of LTSS providers will include the collection of required documents, disclosure statements, and verification that a provider has,

- Valid License or certification to provide services
- Provider cannot be excluded from participation in the Medicare or Medicaid programs
- Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid Provider Number from TennCare
- Has Policies and Procedures in place to conduct criminal background checks as outlined in the Criminal Background check section of this manual.

- Has a Policy and Procedure in place for conducting an individualized assessment for workers whose criminal background check reveal past criminal conduct.

All credentialing requirements and processes can be found in the TennCare/DIDD Credentialing Protocol located on the TennCare LTSS Protocol Webpage.

Providers will comply with all credentialing, recredentialing and initiatives as instructed by Amerigroup, TennCare and/or DIDD. Amerigroup will monitor the quality of services delivered by Provider hereunder and may initiate corrective action when necessary to improve quality of care in accordance with that level of medical or behavioral health care which is recognized as acceptable professional practice in the respective community in which Provider practices and/or the standards established by TennCare. Provider shall comply with corrective action plans initiated by Amerigroup. Provider acknowledges that Amerigroup has the right to monitor Covered Services furnished by Provider to Covered Persons in accordance with Amerigroup policies and procedures that are made known to Provider, and that such monitoring may be announced or unannounced. Provider shall comply with all applicable quality requirements to which Amerigroup must comply as required by TennCare.

Amerigroup may assess liquidated damages, sanctions, or reductions in payment on providers for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to an Amerigroup request for information, the request to provide medical records, credentialing information, etc.; at Amerigroup's discretion or a directive by TENNCARE, Amerigroup shall impose financial consequences against the provider as appropriate.

Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Health care services provided through Amerigroup must be accessible to all members.

New Provider Training

Upon enrollment into Amerigroup's network every provider will go through Orientation and Training, Orientation and Training will be developed in collaboration between the MCOs and DIDD.

REPORTABLE EVENT MANAGEMENT

Reportable Event Management (REM) is one important component of an overall approach for ensuring the health, safety, individual freedom, and quality of life of people participating in home and community-based services (HCBS) and ICF/IID services. REM in Employment and Community First (ECF) CHOICES, 1915(c) waiver, and ICF/IID programs involves a partnership between TennCare, the Department of Intellectual and Developmental Disabilities (DIDD), Managed Care Organizations (MCOs), and providers of HCBS and/or ICF/IID services who all have a role in making REM an effective tool for ensuring the highest possible quality of life by honoring the self-determination of people receiving HCBS and ICF/IID services.

The One Reportable Event Management System protocol aligns with the Dignity of Choice protocol which sets forth expectations for TennCare, MCOs, contracted providers, and DIDD regarding philosophies and practices specific to foreseeable risk identification, assessment, and mitigation in the 1915(c) waiver programs, ECF CHOICES, and ICFs/IID, which identifies a process for addressing dignity of choice through comprehensive assessment, the Person-Centered Support Plan (PCSP) process, and ongoing Support/Care Coordination/Case Management. Dignity of Choice is the right of a person to make an informed decision to engage in experiences

of his or her own choosing, which are necessary for personal growth and development. Supporting dignity of choice means honoring a person's right to make choices and engage in activities that may involve risk associated with these types of choices and activities, and committing to assist the person to identify, consider, and implement strategies to mitigate the identified potential negative consequences of these choices. Dignity of Choice supports the idea that self-determination and the right to take reasonable risks are essential for dignity and self-esteem and so should not be impeded by caregivers concerned about their responsibility to ensure health and welfare.

The overall REM approach must also ensure that people, involved family members, and/or natural supports, as appropriate, are informed about supporting dignity of choice, including informed decision making, tolerable risks, risk mitigation, and how to safely report an event that compromises the health, safety, individual freedom, and/or quality of life of a member.

Consistent with expectations set forth in the federal Person-Centered Planning regulations, person-centered planning in ECF CHOICES, 1915(c) waiver, and ICF/IID programs is intended to identify and mitigate risk of harm, while not placing unnecessary restrictions on the freedom and choices of members; nor preventing opportunities for people to achieve increased independence and autonomy at home and as they participate fully in community life. This has important implications for REM.

Providers and individual staff persons who provide HCBS and/or ICF/IID services are accountable for ensuring the supports are provided in accordance with each Member's PCSP, including implementation of strategies identified to help mitigate risk, but should not be held responsible if, in spite of appropriate supports and implementation of appropriate and reasonable risk mitigation strategies, an untoward event occurs. The ECF CHOICES, 1915(c) waiver, and ICF/IID programs acknowledge and value dignity of choice and recognize that the normal taking of risks in life is essential for personal growth and development and maximizing quality of life. Members are encouraged (with, whenever possible, the support and involvement of their families and natural supports) to pursue and achieve their goals, which inevitably involves taking informed, reasonable risks.

Within ECF CHOICES, the 1915(c) waivers, and ICFs/IID, the REM system is designed to:

1. Clarify non-Reportable Events that providers must address internally through their own quality assurance and event management processes;
2. Define the Reportable Events that must be reported to DIDD and the MCO and the timeframes for reporting;
3. Ensure that provider agencies, their staff, MCO Support Coordinators, the Fiscal Employer Agent (FEA), and others are well informed of their responsibilities to identify events that are reportable;
4. Specify the types of Reportable Events that require investigation or review, by whom (DIDD or provider), the timeframes for such investigations or reviews, and how the person (and/or family and legal representative as appropriate), providers, and others are informed of the results of an investigation or review;
5. Define the processes for requesting a file review of a completed Class 1 Investigation Report, who may request a review, and timelines applicable to the review process; and
6. Ensure a collaborative process between providers, MCOs, and DIDD that identifies and defines trends in order to evaluate the nature, frequency, and circumstances of all Reportable Events, in a manner that leads to actionable steps that are proactive in preventing or reducing similar occurrences.

For the purposes of ECF CHOICES, 1915(c) Waiver and ICF/IID providers, a Reportable Event is an event that is classified as Tier 1 or; Tier 2, or Additional Reportable Events and Interventions, as defined by TENNCARE, that the contracted provider, Amerigroup, or FEA staff-will be responsible for reporting to Amerigroup and/or DIDD, as specified by TENNCARE. The contracted provider, Amerigroup, and/or DIDD, as applicable, shall be

responsible for managing, tracking, and trending in order to prevent similar occurrences in the future whenever possible.

Additional Reportable Events and Interventions – An Additional Reportable Event is an event which is not related to abuse, neglect, or exploitation, that the provider, MCO, or FEA staff shall be responsible for reporting to the MCO and/or DIDD as specified in TENNCARE protocol. A Reportable Intervention is a measure taken to promote the health and safety of the person, which is not related to abuse, neglect, or exploitation, that the provider, MCO, or FEA.

In HCBS and ICF/IID programs, there are three (3) categories of Reportable Events: Tier 1, Tier 2, and Additional Reportable Events and Interventions. The type of Reportable Event dictates the reporting requirements and process that must be followed by the provider, MCO, and DIDD, as applicable. DIDD shall triage all allegations reported via the Abuse Hotline within two (2) business days (unless pending results of medical assessment, laboratory test, expert opinion, etc.) to determine the need for an investigation.

Reportable events will be reviewed by Amerigroup for potential quality of care issues and subsequent action will be taken by Amerigroup per established policy.

Tier 1 Reportable Events-Definition of Tier 1 Reportable Event

- Tier 1 Reportable Events: shall mean the alleged wrongful conduct affecting the person by acts or omissions of abuse, neglect, exploitation, or misappropriation of money or property, that resulted in one or more of the following consequences to the person: death, serious injury, or physical harm; physical or sexual abuse; significant pain, intimidation or mental anguish that required medical intervention or loss of funds or property greater than \$1,000 in value. Notice is given to DIDD Abuse Hotline as soon as possible but within 4 hours, and a typed report is submitted by the Event Management Coordinator (EMC) to DIDD Event Management Unit at Central Office within one (1) business day.

Reporting Requirements for Tier 1 Reportable Events

- Tier 1 Reportable Events must be reported to DIDD's Abuse Hotline (1-888-633-1313) as soon as possible, but no later than four (4) hours after the occurrence of the event or the discovery thereof, and shall also be reported to Adult Protective Services (APS), Child Protective Services (CPS), or law enforcement, as required by law. If a Tier 1 Reportable Event, or any other event that poses an immediate threat to the health and safety of a person, occurs while DIDD, Amerigroup, or provider staff are on site with the person, in addition to reporting this event, such staff shall be required to remain with the person until the threat is removed or the person receives needed medical treatment, if appropriate. Additionally, Amerigroup will maintain an internal system capable of providing DIDD with the PCSP of the person involved in the alleged Tier 1 Reportable Event within two (2) hours of request by DIDD's On-Call Investigator. Amerigroup will provide access to the requested information, if unable to obtain from the supported person's provider. When reporting unexplained or unexpected deaths, providers must inform DIDD's On-Call Investigator and Amerigroup of the person's Do-Not-Resuscitate (DNR) Order (if applicable), safety plan, and an attestation signed by the staff that the lack of life saving actions was justified and preferred by the person.
- Subsequently, the provider Event Management Coordinator (EMC), or designee, shall submit a Reportable Event Form (REF) to DIDD and Amerigroup by close of business the next business day after counting from the date of verbal notification. The provider and Amerigroup will not move forward with their own "reviews" once a Tier 1 Reportable Event has been reported.

- DIDD’s Reportable Event Management Triage is available 24/7 via the Statewide DIDD Investigations (Abuse) Hotline. The On-Call Investigator shall obtain details of the allegation from the reporter and record the information in DIDD’s Reportable Event Management system. The On-Call Investigator shall seek additional information by speaking with the person and/or their legal representative (if applicable), the provider, or other appropriate parties where applicable, via telephone, without the presence of provider staff who may have been involved in or witnessed the event (unless otherwise requested by the person) in order to determine if a Tier 1 Reportable Event must be investigated by DIDD.
- When the On-Call Investigator identifies the event as a Tier 1 that has recently occurred and there is the potential for loss of evidence, the On-Call Investigator shall dispatch the Response Investigator in the respective region to immediately initiate an investigation, coordinate and assist any authorities present at the scene (law enforcement, medical examiner, etc.), interview witnesses and document the scene, and proceed with the collection of evidence when appropriate.
- When the On-Call Investigator is conducting a preliminary review and a face-to-face interview with the person is needed to determine dignity of choice and/or mitigating risks and this cannot be accomplished via telephone, the On-Call Investigator shall dispatch the Response Investigator to assist in facilitating the interview. The Response Investigator shall obtain a statement from the person, any accessible witnesses, and/or any additional evidence available.
- If through the triage process the reported allegation is determined not to meet the criteria for a Tier 1 event, DIDD shall notify Amerigroup and provider of the appropriate REF classification. Amerigroup will communicate with DIDD any insight or concerns upon review of the REF to assist in ensuring the appropriate REF classification is reached.
- Should subsequent additional information be discovered by the event reporter, provider, Amerigroup, or DIDD, the allegation shall be reported to DIDD’s Abuse Hotline with the additional information for review and revision as warranted by the addition of new information.
- The provider EMC or designee will submit a REF to both DIDD and/or Amerigroup by close of the next business day after the occurrence or discovery of occurrence of a Tier 1 Reportable Event.

Process for Investigation of Tier 1 Reportable Events

- For Tier 1 events, DIDD shall notify TennCare, Amerigroup, and provider(s) of the intent to investigate via an Initial Notification. DIDD shall complete a thorough investigation within thirty (30) calendar days of the anchor date, unless an approved extension is granted. A Final Investigative Report shall be provided to TennCare, Amerigroup, DIDD Regional Office, and provider(s).
- Providers are expected to send all information related to the investigation to DIDD as soon as possible upon request. For ECF CHOICES, CHOICES, 1915(c), ICF-IID, and Katie Beckett waiver providers, Amerigroup will be notified and responsible for ensuring provider cooperation with the investigation if provider staff does not send the requested information to DIDD by the following business day. 1915(c), ECF CHOICES, and CHOICES will maintain their current processes for imposing progressive disciplinary action (e.g., monetary sanctions).
- The provider shall instruct all staff that the facts and circumstances being investigated are not to be discussed with anyone except DIDD’s Investigator, law enforcement officers, or other state investigative entities (APS, Department of Children’s Services, Disability Rights TN, etc.).
- If the investigation is not completed within thirty (30) calendar days due to uncontrollable circumstances, such as law enforcement involvement or difficulties obtaining documentation from external entities such as a hospital, DIDD Investigators may request, and upon approval from the Director of Investigations or designee, utilize an extension period of up to an additional thirty (30) calendar days for completion of the investigation. Extensions shall not be utilized for staff convenience. DIDD will notify the provider, Amerigroup, and TennCare of the extension. When an investigation will exceed a thirty (30) calendar day extension pending criminal proceedings, an autopsy report, or law

enforcement requests to remain open, etc., DIDD's Investigator shall complete all field work and the investigative report compiled with all available evidence. DIDD's Investigator shall provide investigation status updates every thirty (30) to ninety (90) days based on the direction of the Director of Investigations or designee as dictated by the circumstances which result in the delay in concluding the investigation. DIDD will notify the Provider, Amerigroup, and TennCare of any extended time periods and the projected date of the investigation closure.

- DIDD shall provide the completed REM Investigation Report and Summary to TennCare, the appropriate Amerigroup, DIDD Regional Office, and provider. The Report and Summary shall include a statement of whether the allegation(s) is substantiated or unsubstantiated. In the case of a substantiation for abuse, neglect, or exploitation, the conclusion shall state if the evidence was clear and convincing (Class 1) or based on a preponderance of the evidence (Class 2). Upon the closure of an investigation resulting in a Class 1 substantiation or a Class 2 substantiation that constitutes the third or more Class 2 substantiation for events discovered or occurring within a rolling twenty-four (24) months period in three (3) separate investigations, the State Investigator or Investigations Specialist shall be responsible for sending the perpetrator a letter notifying him or her of the substantiation(s) and an Election Form that initiates the due process system administered through DIDD Office of Administrative Appeals. The notification letter and Election Form shall be mailed to the perpetrator's address provided at the time of the interview by both regular mail and certified mail. Additionally, the State Investigator or Investigations Specialist shall provide a copy of the notification letter and Election Form to the Office of Administrative Appeals for further follow-up and assist in the due process system as requested.

Investigation Review Committee (IRC)

- All waiver program providers, persons supported, legal representatives, case managers/support coordinators, Amerigroup, DIDD, or TennCare representatives may request a review of an investigative report within fifteen (15) days of an investigation closing. Requests must be based on new or additional information, evidence not considered during the investigative process, raise matters that bring into question the integrity of an investigation, or provide basis for disputing the investigative conclusion. All investigation review requests must be submitted in writing, express the reason for the disagreement, and include additional evidence if applicable. The Committee will not review any file requests that are incomplete or not submitted within the allotted timeframe.
- The request, additional information or evidence, and the investigative report is reviewed by DIDD Director of Investigations (or designee) to determine if there was a critical omission in the investigative process for the investigation. If there was an omission, the investigation may be reopened for the inclusion of the omitted evidence and the potential impact on the conclusion. If the investigation is not reopened, the request proceeds to the Director of Event Management (DEM) for review. If the DEM upholds the request, it will move forward to the IRC. If the DEM does not agree with the request, a summary of the decision will be sent to the General Counsel for final review and disposition of recommendation. The requestor is notified of DIDD's decision within thirty (30) days of receipt of the request.
- The IRC will be provided the investigation, additional information, and requestor's application for review and for the committee deliberation.
- The IRC may (1) uphold the investigative conclusion, (2) modify the investigative conclusion, or (3) overturn the investigative conclusion. The IRC's written decision will be provided to the requestor. The investigative report will be amended for all overturned or modified IRC decisions.

Tier 1 Reportable Event Policy on Administrative Leave or Non-Direct Contact:

- Excluding when an exception is granted by DIDD (as specified below), providers are required to immediately remove an employee or volunteer alleged to have acted in a manner consistent with sexual

abuse or physical abuse resulting in medical treatment, named in a Tier 1 Reportable Event from providing direct support to any person(s) supported until DIDD has completed their investigation, either by placing the named employee or volunteer on administrative leave or in another position in which he or she does not have direct contact with, or supervisory responsibility for, a person(s).

- Providers (i.e., the EMC or agency management, and not the employee or volunteer alleged to have committed physical or sexual abuse) may request an exception to this requirement if:
 - The provider furnishes evidence of consent from the alleged victim (or legal representative of the alleged victim, if applicable);
 - There are no identified risks to persons supported that the employee or volunteer might come into unsupervised contact with;
 - The assigned investigator has interviewed the alleged victim and eyewitnesses to confirm that there are no identified risks to the member or others, and;
 - Safety measures, such as increased supervision and unannounced visits to the place of service by provider management, are undertaken. The provider is expected to ensure that adequate steps are taken for the protection and safety of all persons during the investigation process.
- Such requests are reviewed and either approved or denied expeditiously by DIDD Director of Investigations or designee.
- If a Class 1 substantiation where the allegation is against both the provider and the provider staff person and the provider allegation is substantiated, but the provider staff allegation is unsubstantiated, the provider may request an investigation review by the IRC. In such event, the provider staff person must be allowed to return to work upon release of the Final Investigation report and will not be required to remain on administrative leave until the file review is completed.

Tier 2 Reportable Events-Definition of Tier 2 Reportable Events

- Tier 2 Reportable Events: shall mean the alleged wrongful conduct affecting the person by acts or omissions of abuse, neglect, exploitation, or misappropriation of money or property, that resulted in one or more of the following consequences to the person: intimidation or mental anguish; probable risk of serious harm; loss of funds or property between \$250 and \$1,000 in value or prescription-controlled medications regardless of value; or, through supervision neglect harming a citizen in the community or engaging in criminal acts resulting in arrest and confinement. The person did not require medical intervention/treatment and is not at continued risk of serious harm.

Reporting Requirements for Tier 2 Reportable Events

- Allegations that are reported to DIDD and consistent with the Tier 2 categories/definition, will be referred as appropriate to the provider to perform the investigation (unless the specific provider is excluded from performing their own investigations for another reason further explained below).
- The provider EMC or designee will submit a REF to both DIDD and Amerigroup by close of the next business day counting from the date of witnessing or discovering the Tier 2 Reportable Event.
- For Tier 2 Reportable Events, DIDD Investigations Specialist shall review the REF for the proper classification, along with the MCO. Should the Investigations Specialist or Amerigroup deem additional information is needed to ensure the proper category, DIDD REM Triage system shall be utilized. DIDD shall provide any evidence collected during the Triage Process to the Provider Investigator for any

Tier 2 investigation

- Allegations that are reported to DIDD and consistent with the Tier 2 categories/definition, will be referred as appropriate to the provider to perform the investigation (unless the specific provider is excluded from performing their own investigations for another reason further explained below).

- The provider EMC or designee will submit a REF to both DIDD and MCO by close of the next business day after the occurrence or discovery of occurrence of a Tier 2 Reportable Event.
- For Tier 2 Reportable Events, DIDD Investigations Specialist shall review the REF for the proper classification, along with the MCO. Should the Investigations Specialist or MCO deem additional information is needed to ensure the proper category, DIDD REM Triage system shall be utilized. DIDD shall provide any evidence collected during the Triage Process to the Provider Investigator for any Tier 2 investigation.
- DIDD will be responsible for reviewing all Tier 2 REFs for completeness and for ensuring the Reportable Event has been appropriately identified as Tier 2. Amerigroup will provide DIDD with any additional information for triage to ensure that the correct classification is reached. If DIDD determines that the Reportable Event needs to be reclassified, the REF shall be appropriately reclassified and shared with TennCare, Amerigroup and provider. As part of data collection and analysis, DIDD will monitor and address the frequency of Tier 2 REFs incorrectly classified by the reporting provider (e.g., the event needed to be reclassified as Tier 1 or Non-Reportable Event, or the REF documented an occurrence that is not consistent with the definition of a Tier 1, Tier 2, or Non-Reportable Event).

Process for Investigation of Tier 2 Reportable Events

- Providers shall ensure that all Tier 2 investigations are conducted by a certified Provider Investigator. As part of the certification, provider Investigators must complete the required training as determined by TennCare in collaboration with DIDD.
- All providers are responsible for conducting investigations of Tier 2 Reportable Events and submitting an investigation report for each Tier 2 allegation. A completed investigation report and attachments shall be submitted within twenty-five (25) calendar days of the anchor date. Should the Provider Investigator need advice or assistance with the investigative process, a DIDD Investigations Specialist will be available during normal business hours. The investigation report shall conclude when the investigation is substantiated or unsubstantiated based on the preponderance of evidence. The Provider Investigator shall consider whether the event was the result of a systemic issue or that of an individual. Additionally, the Provider Investigator shall consider Dignity of Choice and actions taken to mitigate risks.
- DIDD's Investigations Specialist shall determine if the provider has met the required standards to conduct Tier 2 investigations and if there is a DIDD certified Provider Investigator. If the provider is eligible to investigate and has a Provider Investigator, the Investigations Specialist shall notify the provider of the allegation and assignment of a Tier 2 Investigation.
- The provider may have multiple DIDD certified Provider Investigators or may contract with a DIDD certified Provider Investigator. The provider shall notify the Investigations Specialist the identity of the Provider Investigator. After verifying the Provider Investigator's certification, the Investigations Specialist shall provide the investigative report template to the Provider Investigator.
- Upon submission of the Tier 2 investigative report to DIDD, an Investigations Specialist shall conduct a review to identify potential evidence that was excluded (such as a witness or documentation), if the analysis supports the definitions for abuse, neglect, and/or exploitation, and if preponderance was supported by the evidence. The Investigative Specialist shall communicate any advice or assistance to the Provider Investigator within three (3) business days of receipt of the report. The Provider Investigator shall make any revisions to the report deemed appropriate and resubmit the final report to the Investigations Specialist, provider, Amerigroup, and TennCare. The provider shall be responsible for the conclusion and findings within the investigation.
- If the investigation is not completed within twenty-five (25) calendar days due to uncontrollable circumstances, such as law enforcement involvement, or difficulties obtaining documentation from external entities such as a hospital, Provider Investigators may request via an Extension Request Form, an extension period up to thirty (30) additional calendar days to complete the investigation. All

extension requests shall be submitted to the Director of Investigations or designee, two (2) business days before the date due for closure. Extensions shall not be utilized for staff convenience. DIDD will notify the Provider, Amerigroup, and TennCare of the extended time period and new date for closure.

- When a provider investigation will exceed a thirty (30) calendar day extension (pending criminal proceedings, law enforcement requests to remain open, etc.) the Provider Investigator shall complete all field work and the investigative report, but the investigation shall not be released until such time a lead investigative entity provides approval to release the information. The Provider Investigator shall provide investigation status updates every thirty (30) days on an Extension Request Form to the Director of Investigations or designee as dictated by the circumstances which result in the delay in concluding the investigation. DIDD will notify the Provider, Amerigroup and TennCare of any extended time periods and the projected date of the investigation closure. The Director of Investigations or designee shall provide TennCare a monthly report for Tier 2 Investigations exceeding dates for closure.
- Should the Provider Investigator discover evidence that would result in the allegation rising from a Tier 2 to a Tier 1, the Provider Investigator shall stop the investigative process immediately and notify the Investigations Specialist (if during normal business hours), or DIDD's Abuse Hotline. The provider must forward the investigation immediately back to DIDD to investigate. A Tier 2 investigation shall not reach a Class 1 conclusion.

Tier 2 Reportable Event Policy on Administrative Leave or Non-Direct Contact

- Providers, after seeking the victim/person's preference and/or that of the legal representative (if applicable), shall determine, at their discretion and in accordance with their policy, whether to remove an employee or volunteer named in a Tier 2 Reportable Event from any or all direct support until the provider has completed their investigation. If the allegation is substantiated as a Class 2, the employee or volunteer may be terminated, or removed until the completion of any action plan (e.g., training) deemed appropriate by the provider. In lieu of removing an employee or volunteer named in a Tier 2 Reportable Event from any or all direct support, the provider may opt to utilize a modified assignment or increased supervision. The provider is expected to ensure that adequate steps are taken for the protection and safety of all persons during the investigation process.

Substantiated Events are classified as Class 1 Events or Class 2 Events:

- Class 1 Events (i.e. the wrongful conduct affecting the person constituted abuse, neglect, exploitation, or misappropriation of money or property, and resulted in one or more of the following consequences to the person: death, serious injury, or physical harm; physical or sexual abuse; significant pain, intimidation or mental anguish; probable risk of serious harm; loss of funds or property greater than \$1,000 in value or prescription controlled medications regardless of value; or, through supervision neglect harming a citizen in the community or engaging in criminal acts resulting in arrest and confinement. Wrongful conduct in this category is of a nature serious enough to call into question whether the offender should be entrusted with the care of a vulnerable person). A final investigative report reflects that the evidence supports that the identified staff acted in accordance with this definition.
- Class 2 Events (i.e. the wrongful conduct affecting the person constituted abuse, neglect, exploitation, or misappropriation of money or property, but resulted in minimal or no physical harm or injury, pain or mental anguish; minimal risk of serious harm; loss of funds or property of up to \$1,000 in value; or violation of plans of care with minimal or no adverse consequences. Wrongful conduct in this category is of a nature that disciplinary action and/or additional training may reasonably be deemed sufficient to address). A final investigative report reflects that the evidence supports that the identified staff acted in accordance with this definition.

- To ensure a comprehensive approach to understanding and preventing future occurrences of Reportable Events, as defined above, the process is also expected to identify applicable, system policies, rules, guidance or other system processes and procedures that may have contributed to the Reportable Event.
- ECF CHOICES, the 1915(c) waiver, and ICF/IID programs are designed to balance health and safety with happiness and personal fulfillment, to ensure persons achieve the best possible employment and community living outcomes and are able to exceed expectations through opportunities to develop and use the gifts, skills and capacities they have to achieve unique and fulfilling lives. REM is expected to reinforce and advance these goals.

Provider Investigator Training

- Providers shall ensure that all Tier 2 investigations are conducted by a certified Provider Investigator. As part of the certification, provider Investigators must complete the required training as determined by TennCare in collaboration with DIDD.

Provider Request for Exception to Investigate

- This process will be utilized if the provider requests not to investigate an allegation and shall result in a DIDD Investigator conducting the investigation. The provider shall be responsible for submitting an Exception to Investigation form to the Director of Investigations or designee within two (2) business days of the anchor date with an explanation related to one or more of the following:
 - Conflict of interest associated with the investigation
 - The complexity of the investigation impedes the provider's ability to investigate when the alleged perpetrator has 3 prior substantiations with that agency within a 24-rolling month period, the provider can request the state to investigate any subsequent investigation.
- The Director of Investigations or designee shall notify the Investigations Specialist for the provider's region when an exception is approved. The Investigations Specialist shall reassign the investigation to a DIDD State Investigator. Additionally, the Investigations Specialist shall track all exception requests and dispositions by provider.

Parameters for determining when a provider is not permitted to conduct provider investigations or status is removed

- Providers who have an overall DIDD QA score lower than "Fair" on the annual survey
- When the provider or an individual of the executive staff is identified as the alleged perpetrator (Program Director or equivalent and above)
- If the provider is less than a year old or until the agency has their first DIDD QA/ECF CHOICES consultative survey
- If the provider does not have a DIDD certified Investigator
- If an ECF CHOICES provider has negative results from a DIDD wellness review performed in the last 12 months that resulted in significant findings related to health and safety. The provider would be eligible to conduct their own investigations after their next DIDD QA survey that scores fair or above.
- If an ECF CHOICES provider is placed on a DIDD moratorium. The provider would be eligible to conduct their own investigations after the moratorium was lifted and they scored fair or above on the following DIDD QA survey.
- Note: TennCare and DIDD have the authority to conduct any investigation, at any time, for any reason deemed appropriate.
- DIDD's Investigations Specialist monitors the provider's status based on information provided by DIDD QA, DIDD Regional Office moratorium notices and wellness reviews, and notification by Amerigroup.

Tier 1 and Tier 2 Investigation Follow-up and Action Plan

- DIDD and Amerigroup are responsible for reviewing investigation reports submitted by DIDD Investigators and Provider Investigators. DIDD Regional Office and Amerigroup will determine the necessity for any follow-up review needed. The provider will complete the Action Plan for all substantiated Class 1 and Class 2 investigations. The substantiation shall address each Informational Findings and late reporting discovered as a means of provider self-improvement.
- Upon acceptance of the final investigative report, the provider will have an additional ten (10) days to complete the Action Plan, which will be tracked by the date in which the Final Investigative Report was closed. The provider will continue to discuss the outcome of the investigation with the person(s) supported and invite the person's legal representative and/or primary contact, if any, to participate in this discussion.
 - The Action Plan shall include the following information:
 - The procedures that have been implemented to mitigate future risks to the person, including steps to prevent similar occurrences in the future;
 - Verification that the substantiated perpetrator(s) was notified of the outcome of the investigation;
 - A statement of what, if any, disciplinary action, training, reassignment, or any other remediation occurred as a result of the findings of the investigation;
 - A response to any informational findings contained in the investigation report.
 - DIDD Regional Event Management Coordinator (EMC) and Amerigroup will review the Action Plan, which shall include any concerns or issues identified. DIDD Regional EMC will include Amerigroup when asking for any additional information within 10 calendar days if the Action Plan submitted does not sufficiently address the identified concerns. The provider has ten (10) calendar days to provide the additional information. DIDD's Regional EMC or designee has forty-five (45) calendar days from the date of closure (release of the Final Investigative Report) to provide a Closure Letter.
 - If allegations were not substantiated, an Action Plan is not required. For both substantiated and unsubstantiated investigations, providers must ensure that informational findings are acted upon in a timely manner. DIDD or Amerigroup can request follow-up action to unsubstantiated Informational Findings, to include Late Reporting.

Additional Reportable Events and Interventions

- Additional reportable events and interventions, which are not related to abuse, neglect, or exploitation, shall also be reported to DIDD Event Management Unit using the REF. The provider EMC or designee shall submit a REF to both DIDD and Amerigroup by close of business the next business day counting from the date of witnessing or discovering a reportable event or intervention. Providers shall be responsible for performing data collection and analysis for all reportable events and interventions.
- The One Reportable Event Management System Definitions Document details what are required Additional Reportable Events and Interventions.

Non-Reportable Events

- Although non-reportable events are not reportable to DIDD/the MCO, providers are expected to document, perform data collection and trend analysis, and address these events internally as part of strategic quality improvement processes that lead to improved outcomes. Provider oversight for non-reportable events will continue to be monitored by DIDD and/or the MCO during annual quality assurance surveys and/or recredentialing, where applicable. It is considered best practice to notify the coordinator, natural support, and/or legal representative as non-reportable events occur to ensure

continuity for the person. Reportable Events Reported by a Person or a Person's Caregiver, Family Member, or Citizen/Friend

- All Reportable Events reported to DIDD, Amerigroup, or provider by a:
 - (1) Person,
 - (2) Caregiver,
 - (3) Family Member, or
 - (4) Citizen/Friend, and
- Having occurred during the provision of HCBS or ICF/IID services, will be documented by DIDD, the provider, or Amerigroup as applicable. DIDD, the provider, or Amerigroup receiving the report will generate a REF within one (1) business day if the reported occurrence is confirmed to be a Reportable Event. The entity receiving the report from the person or the person's natural support (either DIDD, the provider, or Amerigroup) will be responsible for submitting the completed REF to the other entity.
- The provider's EMC or designee will be notified of the Reportable Event by close of the next business day after DIDD or Amerigroup received the report from the person or the person's natural support. These events will follow the same process for Tier 1 and Tier 2 as outlined above.

Fiscal Employer Agent (FEA) Responsibilities

- FEA and provider staff must immediately report, after the occurrence or discovery of occurrence, all instances of suspected abuse, neglect, and exploitation of persons who are adults in accordance with T.C.A 71-6-103, and suspected brutality, abuse, or neglect of persons who are children in accordance with T.C.A 37-1-403 or T.C.A 37-1-605, as applicable.
- All Reportable Events occurring during the provision of HCBS services involving an FEA employee must be reported to DIDD and Amerigroup as outlined in the Tier 1 and Tier 2 reporting processes above and copied to the Employer of Record within the required timeframes.
- In the event a Consumer Direction representative of a person is alleged to have committed abuse, neglect, or exploitation against the person, the representative shall immediately be removed from his or her representative capacity during the investigation. During such removal, the person's participation in Consumer Direction shall be suspended unless another representative can be identified within five (5) business days to serve either on an interim or permanent basis, or the person is determined by DIDD or Amerigroup not to need a representative to continue with Consumer Direction. If the investigation concludes the allegations against the representative are unsubstantiated, the person's participation shall be reinstated if it had been suspended, and the representative's participation in Consumer Direction shall be reinstated if the person determines this reinstatement is appropriate. However, if the allegations against the representative are substantiated, the FEA, DIDD, and/or Amerigroup will work with the person to identify a replacement representative for Consumer Direction. If a replacement representative cannot be identified within ten (10) business days from completion of the investigation, the person shall be disenrolled from Consumer Direction. If disenrolled from Consumer Direction, the person may continue to receive services from a provider. The person may re-enroll in Consumer Direction upon appointing a new representative.

Due Process

- All provider substantiated staff will be eligible to utilize the due process system developed by DIDD. DIDD established the Office of Administrative Appeals (OAA) unit that provides due process opportunities for individuals with a Class 1 substantiation. Wrongful conduct of a Class 1 substantiation is generally serious enough to call into question whether the offender should be entrusted with the care of vulnerable persons. Substantiated individuals will have the right to request a file review, through which the substantiation could be upheld, modified, or overturned, and an opportunity to request a hearing before an Administrative Law Judge.

- The OAA due process system is a bifurcated process between the opportunity for a file review and the opportunity for a trial. Within ten (10) calendar days after an investigation is closed in which substantiated staff receives a Class 1 offense, a letter and Election Form are sent to the substantiated staff by DIDD's Investigator or Investigation Specialist. The letter informs the individual that he/she has the right to request a file review within fifteen (15) calendar days of the date of the letter.
 - If an Election Form requesting a file review is not timely received or if the individual returns the Election Form but waives the right to a file review, then prior to initiating litigation for placement on the Abuse Registry (AR) and/or the Substantiated Investigation Records Inquiry (SIRI), OAA shall conduct an informal preliminary trial and/or placement review to determine whether the substantiation should be upheld or modified and whether the individual should be referred for placement on the AR and/or SIRI. If the Class 1 is reduced to a Class 2, then the due process system concludes, and a letter is sent to the substantiated staff notifying him/her of the action taken and the conclusion of due process. If the substantiation(s) is/are upheld or revised so that he/she still qualifies for due process, then OAA sends a letter and Election Form to the substantiated staff notifying him/her of the opportunity to request a trial to contest the substantiation(s), placement on SIRI, and/or placement on the AR. The timeframe for requesting a hearing is sixty (60) calendar days from the date of the letter. The hearing is conducted pursuant to statute and the rules of OAA and the Administrative Procedures Division of the Secretary of State's office.
 - If an Election Form is timely received by OAA, and the individual requests a file review, then within three (3) business days of receipt, OAA notifies DIDD Director of Investigations (DOI) or designee of the request, including a copy of the Election Form and any supplemental information remitted by the substantiated staff. Within three (3) business days, the DOI notifies OAA whether the case will be reopened. If it is not reopened, OAA accesses the case file, and OAA commences with the file review and renders a decision letter within thirty (30) days of the receipt of the Election Form, unless extended pursuant to the OAA rules. If the case is reopened, the individual is notified via written correspondence from OAA, and the DOI or designee provides an anticipated date of closure for the investigation. Once closed, if the Class 1 substantiation remains founded, then OAA has thirty (30) days from the date of notification of the closure by Investigations to complete a file review and draft a decision letter.
 - If a formal file review decision results in an upholding of the substantiation or a modified finding that includes a Class 1, then OAA drafts a decision letter to the substantiated staff notifying him/her of the decision and the opportunity to request a trial to contest the substantiation(s) and/or placement on the AR and SIRI. If the Class 1 is reduced to a Class 2, then the due process system concludes, and a letter is sent to the substantiated staff notifying him/her of the action taken and the conclusion of due process.
 - If an Election Form pertaining to a hearing is not timely received or the right to a hearing is waived, then the substantiated staff will be referred for placement on the AR and SIRI, without further right to appeal. OAA prepares a referral memorandum and submits it to the Department of Health for inclusion of the substantiated staff's name on the AR. OAA notifies DIDD SIRI Coordinator regarding inclusion of the substantiated staff's name on the SIRI. The DOI and provider agency are notified of the outcome of the matter.
 - If an Election Form pertaining to a hearing is timely received and a hearing requested, then OAA files a Notice of Charges and commences with litigation. The hearing is conducted pursuant to statute and the rules of OAA and the Administrative Procedures Division of the Secretary of State's office. At the conclusion of litigation, the DOI and provider agency are notified of the outcome. If substantiated staff is referred for placement on the AR, then OAA prepares a referral memorandum and submits it to the Department of Health for inclusion of the

substantiated staff's name on the AR, and OAA notifies DIDD SRI Coordinator regarding inclusion of the substantiated staff's name on the SRI.

- The Substantiated Investigation Records Inquiry (SRI) will be accessible for all providers to utilize in reviewing potential employee's substantiation record to assist in hiring decisions. The provider will receive the category of substantiation; the conclusion statement from the final investigative report; and if the offender exercised his/her right to due process, a copy of the OAA decision letter and court ruling, if applicable. Tier 2 substantiations are not included in SRI.

Reportable Event Data Review, Collection, & Analysis

It is especially vital to evaluate the nature, frequency, and circumstances of Reportable Events in order to determine how to prevent or reduce similar occurrences in the future, whenever possible. DIDD will maintain a statewide system for data collection and analysis for all Tier 1 and Tier 2 Reportable Events. All Tier 1 and Tier 2 Reportable Events and data shall be tracked and trended by DIDD on at least a quarterly basis. MCOs and DIDD, in collaboration with their providers, will evaluate the trended data to achieve desired Reportable Event Management outcomes.

Further, DIDD will provide TennCare with comprehensive reports for all programs pursuant to the Interagency Agreement and CRA, as applicable. TennCare receives a trend analysis from DIDD and Amerigroup on all reportable event data, including tracking and trending, on a quarterly basis and uses this information to undertake program level analysis, tracking and oversight for all Reportable Events.

Where a Tier 1 or Tier 2 Reportable Event is determined to be a Class 1 or Class 2 Event the findings shall also include identification of applicable, system policies, rules, guidance or other system processes and procedures that may have contributed to the Class 1 or 2 Event. The provider, Amerigroup and/or DIDD, as applicable, shall be responsible for managing, tracking, and trending in order to prevent similar occurrences in the future.

Each contracted provider is responsible for the designation of an Event Management Coordinator (EMC). ECF CHOICES, CHOICES, Katie Beckett waiver, 1915(c), and ICF/IID provider agencies that provide day, residential and personal assistance services will develop a Provider Reportable Event Review Team (PRERT). The purpose of the PRERT is to review and evaluate the provider's reportable events, investigations, and trends to inform internal prevention strategies. The PRERT shall meet regularly, but no less than monthly, and individualship and representation is specific to each provider's Event Management policy. PRERT meetings will be documented and will reflect discussion and follow up actions concerning reported events and investigations, their causes, actions taken, and recommendations made by the review team.

Reportable Events Quick Reference Guide

- The following details the expectations and requirements that staff and contract CHOICES, Employment and Community First (ECF) CHOICES, 1915(c) and ICF-IID HCBS providers and the Fiscal Employer Agent (FEA), as applicable, report, respond to, and document Tier 1, Tier 2, and Additional Reportable Events and Interventions as indicated in the CRA.

Tier 1: Reportable events	Tier 2: Reportable events
<ul style="list-style-type: none"> • All allegations of sexual abuse • Allegations of physical, emotional, or psychological abuse that required medical intervention or treatment 	<ul style="list-style-type: none"> • Allegations of physical abuse that do not require medical intervention or treatment • Allegations of neglect that do not require medical intervention or treatment

Tier 1: Reportable events	Tier 2: Reportable events
<ul style="list-style-type: none"> • Allegations of neglect that required medical intervention or treatment, and all neglect that is potentially felonious in nature when there is not an injury • All unexplained or unexpected deaths including suicide • A suspicious injury where abuse or neglect is suspected and required medical treatment or intervention, and the nature of the injury does not coincide with explanation of how the injury was sustained <ul style="list-style-type: none"> ○ Serious injury of an unknown cause. For purposes of this section, serious injury shall mean an injury that requires assessment and treatment beyond first aid that can be administered by a lay person. Assessment and treatment for a serious injury is in a hospital emergency room, in an urgent care center, or from a physician, nurse practitioner, or physician's assistant and/or nurse. Includes, but not limited to: decubitus ulcers, fractures, dislocations, concussions, cuts or lacerations requiring sutures, staples, or Dermabond; torn ligaments (e.g. severe sprain) or torn muscles or tendons (e.g. severe strain) requiring surgical repair, 2nd and 3rd degree burns, and loss of consciousness. Serious injuries can be both known and unknown ○ Exploitation by provider personnel (employees or volunteers) of more than \$1,000 (Class E felony) <p>Note: There may be circumstances in which something would not fall under physical abuse, did not result in an injury, but could meet the legal definition for Abuse of a Vulnerable Adult. With DIDD's increased involvement in the Vulnerable Adult Prosecutorial Investigative Team (VAPIT) meetings across the state, the DA may request that DIDD retain an investigation, rather than the Provider.</p>	<ul style="list-style-type: none"> • Allegations of emotional/psychological abuse that do not require medical intervention or treatment, including allegations that provider personnel (e.g. employees, volunteers) engaged in disrespectful or inappropriate communication about a person [e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures)], or any other similar acts that do not meet the definition of emotional or psychological abuse and which are directed to or within eyesight or audible range of the person. <p>Note: Emotional/Psychological Abuse can include an event that negatively affects a person and triggers a behavioral episode but does not require intervention by medical personnel, crisis services such as mobile crisis, EMT, ER, and/or law enforcement, etc. Emotional/Psychological Abuse will also include any such events that would have elicited mental anguish by a reasonably prudent person.</p> <ul style="list-style-type: none"> • Suspicious Injury in which abuse/neglect is suspected but did not require medical treatment or intervention • The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money valued between \$250 and \$1,000 (i.e. less than the threshold for misappropriation).

Additional Events and interventions: Reportable Medical events	Additional Events and interventions: Reportable Behavioral/ Psychiatric events	Additional Events and interventions: Reportable Interventions	Other Reportable events
<ul style="list-style-type: none"> • Cellulitis • Choking episode requiring physical intervention (e.g., use of abdominal thrust, back blows, or Heimlich maneuver) • Deaths (other than those that are unexpected/unexplained) • Fecal impaction • Flu • Insect or animal bite requiring treatment by a medical professional • MRSA • Pneumonia • Pressure Ulcer/Decubitus Ulcer • Seizure progressing to status epilepticus • Sepsis • Serious injury of known cause • Severe allergic reaction requiring medical attention • Severe dehydration requiring medical attention • Skin Infection (other than Cellulitis & MRSA) • UTI <p>Other (please explain on REF) Reminder, please note: Chronic condition shall mean a human health condition or disease that is persistent or otherwise long lasting in its effects, or a disease that comes with time. The term <i>chronic</i> is often applied when the course of the disease lasts for more than 3 months.</p> <p>The provider is required to ensure that any chronic medical conditions are included in the Individual Support Plan (ISP)/Person</p>	<ul style="list-style-type: none"> • Behavioral Crisis requiring protective equipment, manual or mechanical restraints, regardless of type or time used or approved by plan of care (all takedowns or prone restraints are prohibited) • Behavioral Crisis requiring emergency psychotropic medication • Behavioral Crisis requiring crisis intervention • Criminal Conduct/Probable Criminal Conduct: shall mean acts which lead to or can reasonably be expected to lead to police involvement, arrest, or incarceration of a person using services or an employee, during the provision of services. • Engagement with law enforcement • Physical Aggression: shall mean hostile, injurious, or destructive challenging action(s) that are not directly related to property destruction. Physical aggression is reportable with or without injury to the member or others (e.g. Staff). • Property Destruction exceeding \$100 • Psychiatric Admission (or observation), including in an acute care hospital • Reportable Behavior involving physical aggression and/or self-injurious behavior resulting in injury to another person (housemate, staff, private citizen/other) • Self-Injurious Behavior (SIB): shall mean a self-inflicted physical injury 	<ul style="list-style-type: none"> • Abdominal Thrust/Back Blows/Heimlich Maneuver • Administration of PRN Psychotropic Medication • Admission to: Assisted Care Living Facility, Skilled Nursing Facility, ICF/IID, Incarceration, Planned and Unplanned Medical Hospitalization, and Psychiatric Hospitalization • CPR or an Automated External Defibrillator (AED) • Crisis Services: 911 Call, EMT, ER Visit, Fire, Mobile Crisis Services, Police, and Urgent Care Facility • Discharge from: Assisted Care Living Facility, Skilled Nursing Facility, ICF/IID, Incarceration, Planned and Unplanned Medical Hospitalization, and Psychiatric Hospitalization • Manual Restraint • Mechanical Restraint • Protective Equipment • X-Ray (to rule out fracture) 	<ul style="list-style-type: none"> • COVID 19 Positive tests for members ONLY • Administration of Routine Psychotropic Medication without consent • Emergency Situations, including fire, flooding, and serious property damage, that result in harm or risk of harm to persons supported • Fall with Injury – Minor (an injury that is treatable by a lay person) and Serious (resulting in medical intervention and treatment) • Medication Variance and Omission • Missing Person> (greater than) 1 hour; shall mean any person receiving services who is unexpectedly absent for longer than 60 continuous minutes after a reasonable search was conducted. The intent would follow the definition and what was in the person’s PCSP. It should not be interpreted as to limit a person’s rights or freedoms, or on the other hand, that a person could not be “missing” unless 24/7 supervision is required. • Enabling Technology Remote Supports: failure to implement Emergency Back-up Plans • Unsafe Environment (lack of cleanliness/hazardous conditions not otherwise expected to normally exist in the environment) • Vehicle Accident – Minor (not resulting in an injury; treatable by a lay person) and Serious (resulting in medical intervention and treatment); and • Victim of fire.

Additional Events and interventions: Reportable Medical events	Additional Events and interventions: Reportable Behavioral/ Psychiatric events	Additional Events and interventions: Reportable Interventions	Other Reportable events
<p>Centered Support Plan (PCSP). If a condition is not identified as a “chronic condition” within the person’s plan of care, a Reportable Event Form (REF) is required to be submitted. If a “Chronic condition” is identified prior to an annual review, the provider must request that the plan be amended to reflect the change in condition.</p> <p>Note: Choking episodes requiring physical intervention (e.g., use of abdominal thrust, back blows, or Heimlich maneuver) are tracked and trended as a Reportable Medical Event, even if intervention does not occur at an emergency room or urgent care facility.</p>	<p>Note: For SIB to be reportable via REF, there must be an injury that requires assessment and treatment beyond basic first aid that can be administered by a layperson.</p> <ul style="list-style-type: none"> • Sexual Aggression: shall mean acts of a sexual nature, associated with potentially violent behavior of a member, regardless of the desire for participation on the part of the other person. • Suicide attempt <p>Note: The following events are also considered Reportable Behavior/Psychiatric Events, even if they did not require use of a behavior safety intervention or a restrictive behavioral procedure:</p> <ul style="list-style-type: none"> • engagement with law enforcement • property destruction exceeding \$100 • psychiatric admission/discharge • sexual aggression • suicide attempt 		<ul style="list-style-type: none"> •

- Adult Protective Services (APS): Phone: **888-277-8366**, fax: **866-294-3961** or visit online: <https://reportadultabuse.dhs.tn.gov>
- Child Protective Services (CPS): Phone: **877-237-0004**
- DIDD 24/7 Investigations hotlines: Phone **888-633-1313**

	Tier 1 Reportable Events:	Tier 2 Reportable Events:	Additional Reportable Events and Interventions:	Non-Reportable events:
Reportable? To whom?	Yes (DIDD- to the Abuse Hotline; and DIDD and MCO via Reportable Event Form (REF) to designated REM email inboxes) and	Yes (DIDD and MCO via Reportable Event Form (REF) to designated REM email inboxes) and APS/CPS for all abuse, neglect and/or exploitation events, and	Yes (DIDD and MCO via Reportable Event Form (REF) to designated REM email inboxes)	No — events involving allegations of abuse, neglect, and/or exploitation by non-paid supports fall outside of the scope of jurisdiction for DIDD investigations. **Remember to also notify the person’s coordinator and legal

	Tier 1 Reportable Events:	Tier 2 Reportable Events:	Additional Reportable Events and Interventions:	Non-Reportable events:
	<p>APS/CPS for all abuse, neglect and/or exploitation events, and law enforcement when warranted</p> <p>**Remember to also notify the person's coordinator and legal representative.</p>	<p>law enforcement when warranted.</p> <p>**Remember to also notify the person's coordinator and legal representative.</p>	<p>**Remember to also notify the person's coordinator and legal representative.</p>	<p>representative as part of the remediation to decrease the risk of recurrence of these events.</p> <p>Notification to the DIDD Abuse Hotline is not required for non-reportable events; however, all events involving allegations of neglect, abuse, and/or exploitation shall be reported to include APS, CPS, and/or law enforcement as warranted.</p>
Reportable timeline	<p>By telephone: immediately but no longer than 4 hours after occurrence or discovery of occurrence</p> <p>By writing: Completing the REF by close of business the next business day after the occurrence or discovery of occurrence (regardless if the event is deemed to have occurred outside the provision of services) of a Tier 1 Reportable Event via the designated information system.</p> <p>APS/CPS within 24 hrs. For all abuse, neglect and/or exploitation events.</p> <p>Law Enforcement as soon as possible when warranted.</p>	<p>By writing: Completing the REF by close of the next business day counting from the date of witnessing or discovering a Tier 2 Reportable Event via the designated information system.</p> <p>If at any time during remediation/follow-up of any additional event or intervention information is gathered that would result in the event rising to a Tier 1, the entity that discovered the additional information is responsible for following the above-noted reporting requirements for the Tier 1 reporting.</p>	<p>By writing: Completing the REF by close of the next business day counting from the date of witnessing or discovering the Additional Reportable Event/Intervention via the designated information system.</p> <p>If at any time during remediation/follow-up of any additional event or intervention information is gathered that would result in the event rising to a Tier 1, the entity that discovered the additional information is responsible for following the above-noted reporting requirements for the Tier 1 reporting.</p>	<p>If at any time during remediation/follow-up of any additional event or intervention information is gathered that would result in the event rising to a Tier 1 or Tier 2, or additional reportable event/intervention, the provider is responsible for following the noted reporting requirements for the appropriate Tier.</p>

	Tier 1 Reportable Events:	Tier 2 Reportable Events:	Additional Reportable Events and Interventions:	Non-Reportable events:
Who conducts investigation?	DIDD with review by the MCO for potential quality of care issues. For Tier 1 events, DIDD shall notify TennCare, respective MCO(s), and provider(s) of the intent to investigate via an Initial Notification.	All providers are responsible for conducting investigations of Tier 2 Reportable Events and submitting an investigation report via the designated information system. For each Tier 2 event/investigation. Only Certified Provider Investigators can complete Tier 2 Provider Investigations.	Investigation not required	These events will not be investigated by DIDD but still require notification of appropriate outside entities and could be investigated by APS, CPS, and/or law enforcement.
Time frame for investigation	DIDD shall complete a thorough investigation within thirty (30) calendar days of the anchor date, unless an approved extension is granted. A Final Investigative Report shall be provided to TennCare, MCO(s), DIDD Regional Office, and Provider(s).	A completed investigation report and attachments shall be entered in the designated information system. Within twenty-five (25) calendar days of the anchor date by the provider.	N/A	N/A
Administrative leave	Yes, for physical/sexual abuse with exception process; provider policy/discretion for other Tier 1 incident types	At provider discretion and in accordance with provider's policy.	N/A	N/A
Who tracks and trends?	DIDD, MCO and provider	DIDD, MCO and provider	Providers are responsible for performing data collection and analysis for all reportable events and interventions.	Although non-reportable events are not reportable to DIDD or the MCO, providers are expected to document, perform data collection and trend analysis, and address these events internally as part of strategic quality improvement processes that lead to improved outcomes. Provider oversight for non-reportable events will continue to be monitored by

	Tier 1 Reportable Events:	Tier 2 Reportable Events:	Additional Reportable Events and Interventions:	Non-Reportable events:
				DIDD and the MCO during annual quality monitoring surveys and through credentialing site visits with Provider Relations.
Action Plan/Remediation	<p>The provider will complete the Action Plan for all substantiated Class 1 and Class 2 investigations.</p> <p>For investigations completed by APS/CPS/ and/or Law Enforcement, the person's COS, clinicians, etc. will work together to determine steps of remediation as warranted.</p>	10 days after receipt of the final investigation report, the provider will complete the action plan for all substantiated class 2 investigations.	It is considered best practice that the provider, in collaboration with the COS, identifies areas of concern and provides remediation, when applicable, to decrease the event from recurring.	The provider is responsible for appropriate action, including documentation, with review as part of DIDD and MCO quality assurance process

FRAUD, WASTE, AND ABUSE

First Line of Defense Against Fraud

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud regardless of whether or not it is successful.
- **Waste:** Includes overusing services or other practices which, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but rather occurs when resources are misused.
- **Abuse:** When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes or services that are not medically necessary.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member even if that person presents an Amerigroup member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Presentation of a member identification card does not guarantee eligibility; providers should verify a Member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website and telephonic verification may be obtained through the automated Provider Inquiry Line at **800-454-3730**. Providers should encourage members to protect their identification cards as they would a credit card, to carry their health benefits card at all times and report any lost or stolen cards to our company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit identification card can help prevent fraudulent activities. If you or a patient suspect identification theft, call at the Tennessee Office of the Inspector General's Fraud, Waste and Abuse Hotline at **800-433-3982**. Providers should instruct their patients who suspect identification theft to watch the Explanation of Benefits (EOB) for any errors and contact member services if something is incorrect.

Reporting Fraud, Waste and Abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the responsibility to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website and completing the Report [Fraud, Waste and Abuse](#) form.
- Calling Provider Services at **800-454-3730**.

- Calling our Special Investigations Unit fraud hotline at 866-847-8247.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud but be advised that we do not routinely update members who make referrals as it may potentially compromise an investigation.

Examples of Provider Fraud, Waste and Abuse:

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of Member Fraud, Waste and Abuse:

- Forging, altering or selling prescriptions
- Letting someone else use the Member’s identification card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else’s identification card

When reporting concerns involving a member include:

- The Member’s name
- The Member’s date of birth, Social Security Number or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to

all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include but is not limited to:

- Written warning and/or education: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- Medical record audit: We review medical records to substantiate allegations or validate claims submissions.
- Special claims review: A certified professional coder or investigator evaluates claims and places payment or system edits on file. This type of review prevents automatic claim payment in specific situations.
- Recoveries: We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment after 30 days may result in reduced payment of future claims or further legal action.

Acting on Investigative Findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse the provider:

- Will be referred to the Special Investigations Unit
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan, with state approval.

Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of \$5,500 to \$11,000 per false claim.

The FCA also contains qui tam or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under qui tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

- Our company recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to members who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.
- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (e.g., Excel spreadsheets with claim information; such information should be mailed or faxed.)
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box or department at our company.
- Our company voicemail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of individual information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the provider's name, address and TIN or Member's provider number.

Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least \$5 million (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste and abuse.

