TENNESSEE IDD INTEGRATION TRAINING

AGENDA

1. Managed Long Term Services and Supports (MLTSS) Programs
2. Employment and Community First CHOICES (ECF CHOICES) Assessment
3. ECF CHOICES Referral, Intake, and Enrollment Process
4. Authorization Process
5. Programmatic Coordination
6. Person-Centered Support Plan
7. Role of a Provider
8. Electronic Visit Verification and Integration
9. Claims Submission, Payment and Appeal

AGENDA CONTINUED

10. Abuse, Neglect and Exploitation
11. Reportable Event Management
12. Member Appeals Process for Providers
13. Member Grievances
14. Fraud, Waste and Abuse
15. Credentialing
16. ISC Provider Training
17. Ongoing Provider Training

MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAMS

MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAMS

- MLTSS Includes:
  - 1915 (c) HCBS Waivers
    - Statewide Waiver
    - Self-Determination Waiver
    - Comprehensive Aggregate Cap (CAC) Waiver
  - Employment and Community First CHOICES (ECF CHOICES)
    - Serves individuals of all ages with a diagnosis of Intellectual/Developmental Disabilities
    - There are 5 Groups within Employment and Community First CHOICES
      - Group 4
      - Group 5
      - Group 6
      - Group 7
      - Group 8

MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAMS

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
  - These are institutional settings within the community that work with individuals with an Intellectual Disability
- TennCare CHOICES
  - Serves individuals over 65 years of age or 21 and over with a physical disability
  - 3 Groups:
    - Group 1 resides in a NF
    - Group 2 meet NF criteria but desire to remain in the community with assistance from HCBS Providers
    - Group 3 are at risk for meeting NF criteria and need assistance to remain independent in the community

ECF CHOICES ASSESSMENTS

ECF CHOICES LEVEL OF CARE (LOC) ASSESSMENTS

- ECF CHOICES uses nursing facility (NF) level of care (LOC), NOT ICF-IID LOC like in the 1915(c)
- TennCare provides the LOC assessment to the MCOs
- LOC assessments are the core foundation of support coordination
  - LOC assessments help determine and ensure that members receive the right level of care at the right time
- LOC assessments are part of the annual assessment process
  - In order for a LOC assessment to be counted as an annual LOC assessment, the full annual assessment visit must be completed
- If LOC assessment is completed anytime outside of an annual assessment it is considered an additional LOC assessment

ECF CHOICES LEVEL OF CARE (LOC) ASSESSMENTS

Change in the member's functional or medical status that may affect the member's level of care will require a LOC assessment be completed.

- These should be conducted **within 5 business days of notification** that a change or serious event has occurred.

- Examples include but are not limited to:
  - Hospitalization
  - Significant changes

ECF CHOICES COMPREHENSIVE ASSESSMENT

- Upon enrollment in ECF CHOICES and as specified on an ongoing basis, the Support Coordinator shall conduct a comprehensive face-to-face comprehensive assessment using a tool prior approved by TennCare and in accordance with protocols specified by TennCare.
- The comprehensive assessment shall be conducted at least annually and as the Support Coordinator deems necessary.
- For ECF CHOICES members, the Support Coordinator 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 the MCO contract with TennCare.
- 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.

ECF CHOICES COMPREHENSIVE ASSESSMENT

- At minimum, for members in ECF CHOICES, the comprehensive assessment shall assess:

(1) The member's strengths

(2) The natural and community supports (both currently involved and yet to be involved) available to the member, and the extent of the stability of each of those supports

(3) The member's preferences for lifestyle, employment, daily routine and community involvement, privacy, and direct support professionals

(4) The member's goals and needs related to: achieving his/her desired lifestyle and personal goals (including employment and community involvement goals); achieving and maintaining the best possible health and wellness; preserving and building natural and community supports; developing and maintaining a network of chosen and positive relationships; building skills and strategies for independence; achieving the greatest possible financial capabilities to maximize the member's ability to control personal income and other financial resources; understanding and exercising his/her rights, preserving guardianship of self, executing advance directives, utilizing durable power of attorney and/or power of attorney for health care; obtaining and maintaining safe, stable and affordable housing; building and preserving financial health; and mitigating risks associated with the member's desired lifestyle, chosen relationships, housing situation and/or impact of disability

ECF CHOICES COMPREHENSIVE ASSESSMENT

ECF CHOICES Comprehensive Assessment components continued:

(5) The member's overall wellness including physical, behavioral, functional, and psychosocial needs;

(6) On-going clinical and/or functional conditions that may require intervention, a course of treatment and/or on-going monitoring;

(7) Any vulnerability and risk factors for abuse and neglect in the member's personal life or finances;

(8) Services or assistance programs the member may be receiving, may have access to and/or may be eligible for, in addition to, or in lieu of, services available through ECF CHOICES;

(9) Supports, services, or items necessary to enable the member to achieve his/her preferred lifestyle and goals, to ensure community living, to facilitate gainful integrated employment, and to delay or prevent a decline in level of independence and functioning.

ECF CHOICES COMPREHENSIVE ASSESSMENT

ECF CHOICES Comprehensive Assessment components continued:

- As a part of the comprehensive assessment, the MCO shall review the American Association of Intellectual and Developmental Disabilities Supports Intensity Scale results/reports (applicable for ECF CHOICES Group 6 members only), all available medical records of the member and any other available background information.
- The comprehensive assessment shall determine how natural and community supports available to the member can best be coordinated and supported through the ECF CHOICES program.
- The comprehensive assessment shall include exploration with the member of the member's understanding of consumer direction and any desire to self-manage all or part of services available through consumer direction as specified in the PCSP.

ECF CHOICES REFERRAL, INTAKE, AND ENROLLMENT PROCESS

ECF CHOICES REFERRAL PROCESS

ECF CHOICES referrals may be submitted by the methods below:

- Self-referral on the TennCare website: https://tpaes.tenncare.tn.gov/tmtrack/ecf/index.htm
- If someone already has TennCare, the individual may contact their respective MCO for assistance:
  - Amerigroup Community Care- **866-840-4991**
  - BlueCare- **888-747-8955**
  - United Health Care Community Plan- **800-690-1606**

- If someone does not have TennCare, the individual may contact the DIDD Regional Offices for assistance:
  - West Tennessee Regional Office **866- 372-5709**
  - Middle Tennessee Regional Office **800-654-4839**
  - East Tennessee Regional Office **888-531-9876**

ECF CHOICES INTAKE PROCESS

Intake Process

- Reserved Capacity Groups:
  - Aging caregivers
  - Emergent situation
  - Multiple complex health conditions
  - Planned transition
  - Supports sustained current family

- Priority Groups:
  - Employment Related (1-8 categories)

- Other Enrollment Groups:
  - Other active
  - Deferred

ECF CHOICES Referral, Intake and Enrollment Process – Priority Categories 1-8

1. An applicant of any age who is currently employed and needs supports to maintain employment

2. Applicants 18-22 years old who are transitioning from school and are employed or have a commitment from an employer and need support

3. An applicant of any age who's recently unemployed and needs support to obtain new employment

4. Applicants 18-22 years old who are transitioning from school with expressed interest in employment

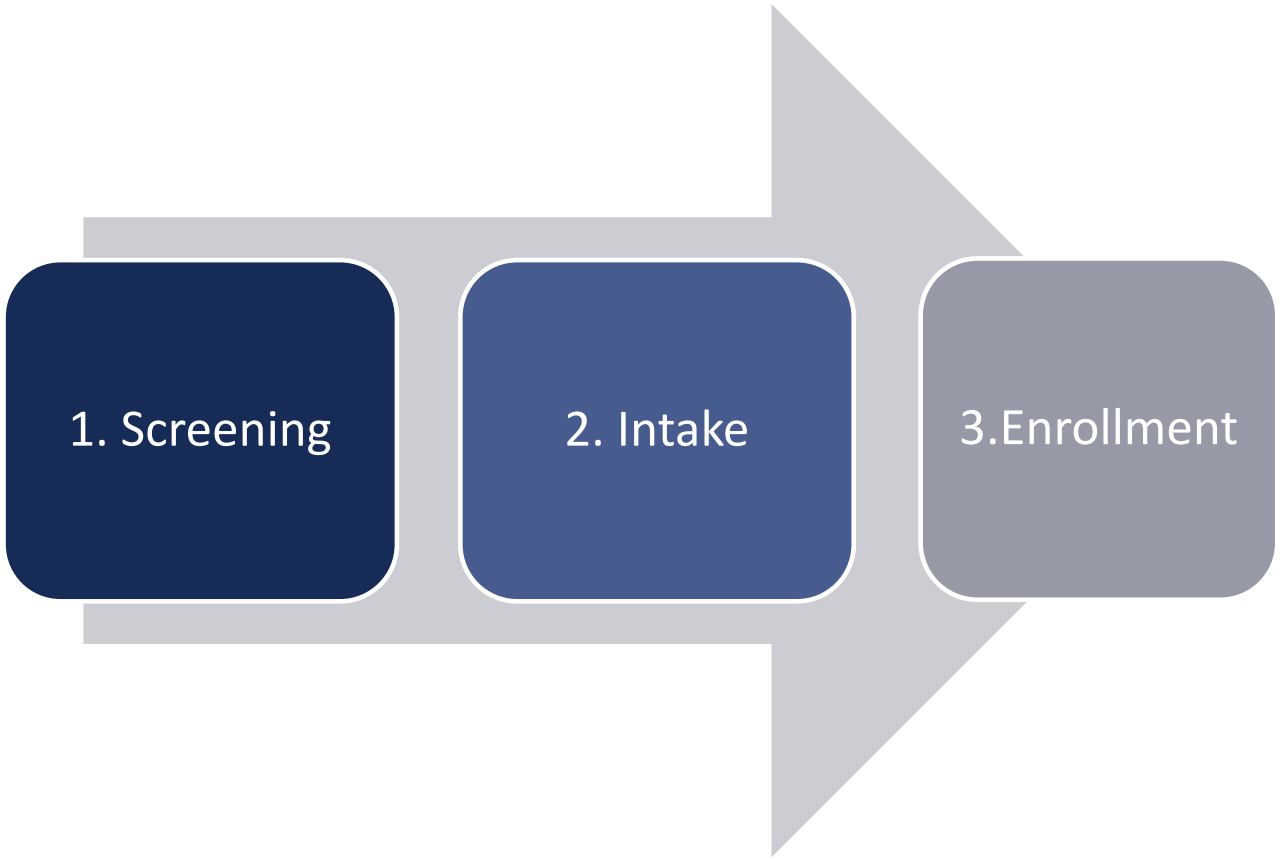
5. Applicants who are unemployed with a desire and commitment to work

6. Transition-age youth living at home and planning for employment supports

7. Applicants 21 years and older who aren't currently committed to working but are willing to explore potential employment options

8. Applicants 65 years and older who aren't interested in employment but need support to participate in integrated community living

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS



ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

- The ECF CHOICES self-referral and screening process is mandatory. For both programs, such screening process shall assess:

(1) whether the potential applicant appears to meet categorical and financial eligibility criteria for CHOICES or ECF CHOICES, as applicable; and

(2) whether the potential applicant appears to meet level of care eligibility for enrollment in CHOICES or ECF CHOICES. For ECF CHOICES, the screening process shall also gather information that can be used by TennCare to prioritize the potential applicant for intake based on established prioritization and enrollment criteria. If the initial contact is not telephonic, or if TennCare or its designee is not able to provide assistance at the point of contact, within two (2) business days, TennCare or its designee shall contact the applicant to provide assistance to the potential applicant, as needed, in completing the online self-referral.

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

- Intake visits for potential CHOICES or ECF CHOICES applicants shall occur in the potential applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing
- Intake visits include the completion of a variety of forms and assessments
- The MCO shall complete all intake processes within thirty (30) calendar days, unless an exception is granted by TennCare in writing due to extenuating circumstances beyond the MCOs control.

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

ECF CHOICES Intake Packet FORMS

1. Intake outcome form (ALWAYS required)
2. Life Skills Assessment (if applicable)
3. Discontinue Intake form (if applicable)
4. Documentation of Target Population (TP)
5. Any legal documents (if applicable)
6. Reserve capacity documentation
7. Proof of age of caregiver (for aging caregiver ONLY)

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

- TennCare approves and enrolls members into ECF CHOICES in accordance with criteria set forth in the approved 1115 waiver and TennCare rule.
- The MCO shall ensure that upon a member's enrollment in ECF CHOICES, if applicable, all High Risk Population Health Management MCO activities are integrated with ECF CHOICES Support Coordination processes and functions, and that the member's assigned Support Coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and LTSS.

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

- As part of the enrollment visit for ECF CHOICES, TennCare or the MCO shall, as applicable and in accordance with requirements set forth in protocol:

  (1) Confirm or update, as applicable, the applicant's current address and phone number(s)

  (2) Review ECF CHOICES education and information, as specified by TennCare, and assist in answering any questions the applicant may have;

  (3) make sure the applicant is aware that DIDD policy does not permit a person enrolled in ECF CHOICES to enroll in the Family Support Program operated by DIDD

  (4) complete level of care (i.e., PAE) and Medicaid applications and provide assistance, as necessary, in gathering documentation needed by the State to determine medical and financial eligibility for reimbursement of LTSS, including post-eligibility provisions (i.e., patient liability)

  (5) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

(6) provide information about estate recovery;

(7) provide detailed information and obtain signed acknowledgement of understanding regarding an ECF CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability;

(8) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and

(9) Provide information regarding next steps in the process including the need for approval by TennCare to enroll in ECF CHOICES and the functions of the MCO upon enrollment, including that the MCO shall work with the applicant to develop and approve a PCSP in accordance with protocols developed by TennCare and the principles of self-determination, including dignity of choice and supported decision-making. The MCO shall discuss with the applicant opportunities, benefits, and potential negative outcomes associated with risks that may result from the applicant's decisions, and strategies to mitigate potential negative outcomes associated with identified risks.

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

- The enrollment visit shall be face-to-face, except in circumstances where TennCare's designee has already completed actions required as part of the enrollment process and obtained the required signatures during the face-to-face intake visit, in which case TennCare's designee may proceed with enrollment, and shall contact the ECF CHOICES applicant either in person or telephonically within five (5) business days of the decision to proceed with enrollment to inform the applicant that TennCare's designee shall be completing and submitting the PAE on the applicant's behalf, and will explain that the applicant will receive the outcome of this submission from TennCare via mail.

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

- The MCO shall document immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs in the PCSP and
- Shall authorize and initiate any immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs within ten (10) business days of receiving notice of a member's enrollment, or as expeditiously as needed to facilitate timely discharge, avoid inappropriate placement, or to avoid imminent loss of competitive integrated employment or an offer of such employment.
- In the case of immediately needed ECF CHOICES HCBS, initiation shall include the commencement of the actual provision of services (or other covered benefits or cost-effective alternative services).
- Any ECF CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed shall continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly.
- For ECF CHOICES members who were enrolled under one of the employment-related priority categories, the development of the person centered support plan process shall first address, the goals and support/service needs specific to the employment-related priority category through which the member gained enrollment into the program.

ECF CHOICES REFERRAL, INTAKE AND ENROLLMENT PROCESS

ECF CHOICES Enrollment documents:

1. Applicant Interview (ALWAYS required)
2. Collateral interview (ALWAYS required)
3. PAE (ALWAYS required)
4. Safety Attestation (ALWAYS required)
5. MCO Financial Eligibility Checklist (ALWAYS required)
6. Consumer Direction Participation Form (ALWAYS required)
7. Patient Liability (ALWAYS required)
8. Caregiver Assessment (ALWAYS required)
9. LTSS Financial Application (may or may not be needed on back end)
10. Supports Intensity Scale (SIS) (only if requesting group 6)
11. Inventory for Client and Agency Planning (ICAP) Assessment (only if scored on "behavior" section of Pre-Admission Evaluation)

AUTHORIZATION PROCESS

AUTHORIZATION PROCESS – UNCHANGED FOR 1915 (c) WAIVERS

All Waiver Services require authorizations	ISCs coordinate authorized services	Accepted services must be provided as documented on authorizations
Continue submitting authorized services rendered to DIDD.	DIDD confirms authorized services.	Authorized services will be submitted to MCOs via files.
MCOs will process claims on files from confirmed services from DIDD file.	MCOs will reimburse providers based upon DIDD file.	Enroll in EFT for convenient electronic reimbursement with MCOs.

- DIDD will continue to oversee the authorizations as applicable for approved services on the Service Plan.
- The ISC/CM will continue to coordinate with waiver providers to obtain information to complete authorizations.
- Including are authorizations due to ongoing or amended services on the Care Plan.
- Total hour of services authorized and approved will still be subject to individual cost limits prior to completing authorizations.

AUTHORIZATION PROCESS – CHANGES FOR ICF/IID

MCOs received a list members currently being supported in ICF/IIDs.

MCOs responsibility is to facilitate and develop authorizations for all members receiving current and ongoing services received in ICF/IIDs (including new members).

Providers will receive new authorizations created by MCOs effective 10/1/2021.

MCOs will reimburse ICF/IID providers according to approved authorizations as applicable for enrolled members.

- MCOs will oversee Community Informed Choice process for current members, DIDD will handle for non-members seeking admission to ICF/IID.
- MCOs shall have in place an authorization process for ICF/IID services for eligible members as approved by TennCare.

AUTHORIZATION PROCESS - EXISTING MCO HCBS

All service authorizations identified within an ECF CHOICES or CHOICES member's PCSP must be authorized and have an identified provider prior to the initiation of the service.

Once a provider is identified and commits to providing services within contractual timeframes, the Person Centered Support Plan (PCSP) is submitted to the provider for Groups 2-8 members.

Contracted providers are obligated to deliver services in accordance with the PCSP, including the amount, frequency, intensity, and duration of services specified in the PCSP.

No.	Service	Task	Freq-uency	Hours/ Amt	Service Start Status	Start Date	End Date	Daily Schedule	Time Schedule Start
1.	Personal Care Visits	all ADLs and IADLs such as, housekeeping, bathing, dressing, grooming, toileting, transferring, meal prep, errands, and	3 days a week	4	Pending CHOICES Enrollment	9/4/2013	3/1/2014	M, W, F	9 AM-11 AM

PROGRAMMATIC COORDINATION

Coordinator	Program	Reports To	Collaboration Responsibilities
Care Coordinator (CC)	CHOICES	MCO	Member / MCO / Provider/FEA (as applicable)
Support Coordinator (SC)	ECF CHOICES	MCO	Member / MCO / Provider / FEA (as applicable)
Independent Support Coordinator (ISC)	1915(c) CAC Waiver and Statewide Waiver	ISC Agencies	Member & Representative / MCO / DIDD / Provider /FEA (as applicable)
DIDD Case Manager (CM)	1915 (c) Self-Determination Waiver	DIDD	Member & Representative / DIDD / Provider/ FEA (as applicable)

CC, SC, ISC, DIDD CM Coordination Responsibilities

- Facilitate person-centered planning process including the COS
- Assessments of strengths, needs, and preferences, including Enabling Technology
- PCSP Development with individualized goals, leveraging natural supports
- Assist with back-up plan
- Support member’s desired lifestyle
- Facilitate Member’s Provider selection
- Address any modifications to HCBS settings requirements
- PCSP implementation, monitoring, and updates
- Transition 21
- Assure budgetary compliance
- Educate member on waiver program and services, rights and responsibilities, and informed choice

CC, SC, ISC, DIDD CM Coordination Responsibilities (Continued)

- Facilitate Employment Informed Choice process with the expectation of exploring employment
- Support full community access, assuring health and safety
- Help with appeals
- Ensure continuity/coordination of PH, BH, LTSS, educating member on benefits
- Facilitate ICF/IID, NF, SNF, provider and MCO transitions
- Offer Self-Direction / Consumer-Direction
- Report to DIDD when PCSP is not being implemented
- Collaborate with CD Fiscal Employer Agent (FEA) Supports Broker

ICF/IID Interdisciplinary CARE TEAM Coordination Responsibilities

- Ensure person-centered continuity, coordination and collaboration among PH, BH, and LTSS providers, including appropriate management of chronic conditions. Coordinate specialized services for individuals with ID or related conditions.
  - Prepare and monitor Comprehensive or baseline care plan
    - Goals and desired outcomes
    - Medications & Dietary Restrictions
    - Services and Treatments
  - Evaluation and re-evaluation
  - Discharge and transition planning
    - Discharge summary

PERSON-CENTERED SUPPORT PLAN

PERSON-CENTERED SUPPORT PLAN (PCSP)

- A PCSP is a comprehensive plan that includes a person's individually identified employment, community living, health and wellness goals.
- It identifies Medicaid and Non-Medicaid services and natural supports necessary to achieve individually identified employment and other outcomes integrated in the community.
- The plan includes the current status; desired future status; and supports needed to achieve goals.
- The PCSP should evolve to meet needs, as changes occur.

PERSON-CENTERED SUPPORT PLAN (PCSP)
1915(C) WAIVER CHANGES AND RATES

Rates

- Waiver HCBS Services, as they are defined in the approved waiver applications will be in the PCSP, including the amount, frequency, and duration, as well as the selected provider.
- Rates of reimbursement for Waiver HCBS will be identified separately once the PCSP is reviewed/approved.
  - Rates (or justification for rates of reimbursement) will **not** be part of PCSP.
- Rates of reimbursement are based on the assessed level of support needed.
  - If the currently approved rate of reimbursement for a service differs from the person's assessed level of support need, for now, the currently approved rate of reimbursement will continue to be approved.
  - Future transition to a more objective approach for assessing level of support need (e.g., use of the SIS) will take into account individualized review of exceptional medical and behavioral needs, and will provide ample opportunity for stakeholder input.
- For now, in Statewide and Self-Determination waivers, ISCs/DIDD CMs will use currently approved rates to ensure that services remain within applicable individual cost limit
- Any changes to a person's level of need or requests for changes in a rate of reimbursement should be addressed **by the provider** with DIDD *at the time such changes occur*—not as part of PCSP review/submission

ROLE OF A PROVIDER

ROLE OF A PROVIDER

- Assist the MCO's to ensure that the individuals that we serve live fulfilling and rewarding lives by providing quality services
- Provide individualized care as outlined in Person Centered Support Plan (PCSP)
  - Keep the person the center focus of the PCSP and services provided
  - Utilize person centered language throughout the PCSP and provider documentation
  - Deliver person centered services in a respectful and dignified way
  - Involve the person (and/or conservator, family, those he/she chooses) in decision making
- Open and on-going communication with the MCO's to create a holistic approach for the individual's medical needs, engaging multi-disciplinary teams to address area of concern

ELECTRONIC VISIT VERIFICATION (EVV) AND INTEGRATION

ELECTRONIC VISIT VERIFICATION (EVV) AND IDD INTEGRATION: UNCHANGED

- During the initial implementation of IDD Integration, EVV processes will remain the same as they are currently for both DIDD and MCOs

CLAIM SUBMISSION, PAYMENT AND APPEAL

CLAIMS SUBMISSION, PAYMENT AND APPEALS

- Current process is not changing…
  - 1915(c) providers will continue to submit claims through DIDD's portal
  - ICF/IID providers will continue to submit claims through TennCare's portal
- MCOs will receive claim information electronically and pay within **7 calendar days** through our individual payment platforms
- Providers will receive a remit from each MCO to post payments
  - Providers are encouraged to sign up for Electronic Funds Transfer (EFT) with each MCO
  - Existing contracted providers do not need to sign up again, if an EFT arrangement with each MCO is already established

CLAIMS SUBMISSION, PAYMENT AND APPEALS CONT.

What is changing?

- Timely Filing
  - Timely Filing standards require providers to submit claims within 120 days from date of service is rendered
  - Claims submitted after the 120-day filing deadline will be subject to denial
  - Corrected claims must be submitted within 120 days from the date of services or within 60 days from the date of the Explanation of Payment (EOP), whichever is later
  - As providers get systems in place to meet the changed timely filing requirements, technical assistance will be available to providers
    - Each MCO will make available resources to assist with any claims related questions or training needs
- Appeals
  - Amerigroup- via our Availity Web Portal or by calling 866-840-4991
  - BCBST- https://provider.bcbst.com/tools-resources/coverage-claims
  - UnitedHealthcare Community Plan- UHCprovider.com

ABUSE, NEGLECT AND EXPLOITATION

ABUSE, NEGLECT AND EXPLOITATION

- In the event of Abuse and/or Neglect, report suspected abuse, neglect and/or exploitation of a member within 24 hours to:
  - Child Protective Services (CPS) Hotline: 1-877-237-0004
    https://apps.tn.gov/carat/referral/emergency.html
  - Adult Protective Services (APS) Phone: 1-888-277-8366; APS Fax: 1-866-294-3961
    https://reportadultabuse.dhs.tn.gov/
- Providers must also follow the process for One System Reportable Event Management, as detailed on the DIDD website, including reporting to the DIDD Abuse Hotline as soon as possible, but no more than four (4) hours after the occurrence of the event or discovery of the event
  - DIDD Abuse Hotline: 1-888-633-1313

ABUSE, NEGLECT AND EXPLOITATION

In addition, providers must:

- Take immediate action to ensure the health and safety of the member
- Notify emergency medical services and law enforcement, if warranted
- With any allegations of physical or sexual abuse relating to a worker, providers are required to place the worker on administrative leave or in another position in which he or she does not have direct contact with, or supervisory responsibility for, a person supported until the investigation is completed, unless an exception has been granted by DIDD. This is outlined within the Reportable Event Tier 1 language.

REPORTABLE EVENT MANAGEMENT

ONE REPORTABLE EVENT MANAGEMENT SYSTEM

- 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).

- It is a collaborative partnership between:
  - TennCare
  - Department of Intellectual and Developmental Disabilities (DIDD)
  - Managed Care Organizations (MCOs)
  - Home and Community Based Services (HCBS) providers

ONE REPORTABLE EVENT MANAGEMENT SYSTEM

- The REM System is designed to:
  - Clarify Non-Reportable Events that providers must address internally
  - Define Reportable Events that must be reported to DIDD and the MCO
  - Ensure that all are well informed of their responsibility to identify Reportable Events
  - Specify the types of Reportable Events that require investigation or review
  - Ensure a collaborative process in preventing/reducing similar occurrences

ONE REPORTABLE EVENT MANAGEMENT SYSTEM

- Training regarding the REM System is in process through collaborative efforts with DIDD, TennCare and the MCOs.
- Please refer to training requirements on the DIDD website:
  - https://www.tn.gov/did/providers/r-e-m.html
- Questions can be submitted to:
  - **Amerigroup-** ECF-REF@Amerigroup.com
  - **BlueCare -** ReportableEvents@bcbst.com
  - **UnitedHealthcare-** tn_quality_review@uhc.com
  - **Department of Intellectual and Developmental Disabilities (DIDD)-** DIDD.REMHelp@tn.gov

MEMBER APPEALS PROCESS

MEMBER APPEALS

- The Division of TennCare governs members' rights and responsibilities related to denials and ensures a timely and fair appeals process.
- An appeal is the process where a member wants to pursue a reconsideration of an adverse action (e.g., delay, denial, reduction or termination of services).

Types of Appeals

- **Member Appeals** – An adverse action occurred and services **have not** been rendered.
- **Standard Provider Appeals** – A denial of a service occurred and the services **have** been rendered with no adverse action to the member.
- **Expedited Appeals** – A denial of service occurred and the provider thinks the adverse determination could jeopardize a member's life or health and the ability to regain maximum function or subject the member to severe pain that cannot be managed without care or treatment.
- **Reimbursement Appeals** – Requesting to be reimbursed for an out-of-pocket expense or requesting relief of billing when the member receives bills from a health care provider.

MEMBER APPEALS

How to File an Appeal

- Members (or their representatives) have 60 calendar days from the date on the denial notice to submit an appeal to the Division of TennCare.
  - To continue existing services, a request for continuation of benefits must be filed within 10 calendar days.
- Providers can appeal on behalf of the member by filing an appeal with TennCare Solutions if services have not been rendered. These are considered member appeals.
  - Members must include a signed consent form for the provider to submit an appeal on the member's behalf
  - Phone: TennCare Solutions: 1-800-878-3192
  - Fax: TennCare Solutions: 1-888-345-5575

Type of Appeal	Turn Around Time	Total Process Time
Expedited Member Appeal	72 hours	1 week
Standard Member Appeal	14 Calendar days	90 days
Accelerated Member Appeal	5 Calendar days	31 calendar days

MEMBER APPEALS

How to File Continued

- Mail: TennCare Solutions
  P.O. Box 000593
  Nashville, TN 37202-0593

- Division of TennCare– Home Page: http://www.tn.gov/tenncare

- TennCare Rules: https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm
  - See Chapter 1200-13-13

- TennCare Medical Appeal Form: https://www.tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html

MEMBER GRIEVANCES

DIDD CUSTOMER FOCUSED SERVICE

- DIDD Customer-Focused Service is pleased to announce a streamlined single-entry point for advocacy, complaint resolution, conflict resolution and mediation for persons supported in the 1915c waiver
  - Customer-Focused Service is committed to assisting persons supported, 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 person supported, 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 person supported. Customer-Focused Service refers allegations of abuse, neglect, or exploitation to the 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

MEMBER GRIEVANCES- AMERIGROUP

- A Grievance is a complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.
- Each MCO has a Grievance System, which is the process to handle grievances
- Amerigroup will assist with the grievance/complaint process, including but not limited to completing forms, etc.

MEMBER GRIEVANCES- AMERIGROUP

Grievances…

- Can be filed either orally or in writing
- Will be acknowledged within five (5) days of receipt
- Will be resolved, to include notification of the resolution being sent in writing to the individual
  - This will be done as quick as possible but no later than ninety (90) days from the date the grievance/complaint is received by the MCO

For a Member to submit a Grievance to Amerigroup,

- Contact our National Call Center at 1-800-600-4441

You can also visit our Amerigroup Member Portal to find the full Member handbook at the link below,

https://www.myamerigroup.com/tn/tntn_caid_mhb_eng.pdf

MEMBER GRIEVANCES- BLUECARE

- Per the BlueCare Contractor Risk Agreement, a Grievance is defined as:
  - A complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination
  - Grievances may include, but are not limited to:
    - The quality of care or services provided,
    - Rudeness of a provider or employee, or
    - Failure to respect the enrollee's rights regardless of whether remedial action is requested
- Member Grievances can be filed in writing or orally
- Member Grievances must be resolved within 90 calendar days
- An acknowledgement letter to the member is required within 5 business days
  - This is not required if the grievance is resolved within 5 business days
- A resolution letter must be sent to the member for every grievance received
- A grievance can be received by any BlueCare Staff Member
  - The staff member who receives the complaint will work with the member to resolve the complaint
  - Members can file a grievance by Calling into our Member Service Department or sending by mail:

Member Services	Mail Written Grievance
BlueCare – (800) 468-9698 TennCare*Select*- (800) 263-5479	BlueCare / TennCare Select Claims Service Center 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002

MEMBER GRIEVANCES- UNITEDHEALTHCARE

- Per the UnitedHealthcare Community Plan Contractor Risk Agreement, a Grievance is defined as:
  - A complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determir
  - Grievances may include, but are not limited to:
    - The quality of care or services provided,
    - Rudeness of a provider or employee, or
    - Failure to respect the enrollee's rights regardless of whether remedial action is requested
- Member Grievances can be filed in writing or orally
- Member Grievances must be resolved within 90 calendar days
- An acknowledgement letter to the member is required within 5 business days
  - This is not required if the grievance is resolved within 5 business days
- A resolution letter must be sent to the member for every grievance received
- A grievance can be received by any UnitedHealthcare Community Plan Staff Member
  - The staff member who receives the complaint will work with the member to resolve the complaint
  - Members can file a grievance by Calling into our Member Service Department or sending by mail:

Member Services	Mail Written Grievance
UnitedHealthcare Community Plan – (800) 690-1606 **CoverKids- (866) 600 - 4985**	UnitedHealthcare Community Plan P.O. Box 5220 Kingston, NY 12402-5220

FRAUD, WASTE AND ABUSE

Knowingly presents to an officer or employee of the U.S. Government or member of the Armed Forces of the United States a false or fraudulent claim for payment or approval

The False Claims Act Covers Liability for Certain Acts

(Title 31 U.S.C., Section 3729)

CONSPIRES TO DEFRAUD THE GOVERNMENT BY GETTING A FALSE OR FRAUDULENT CLAIM ALLOWED OR PAID

AUTHORIZES TO MAKE OR DELIVER A DOCUMENT CERTIFYING RECEIPT OF PROPERTY USED, OR TO BE USED, BY THE GOVERNMENT, WITHOUT COMPLETELY KNOWING THAT THE INFORMATION ON THE RECEIPT IS TRUE

KNOWINGLY MAKES, USES, OR CAUSES TO BE MADE OR USED, A FALSE RECORD OR STATEMENT TO CONCEAL, AVOID, OR DECREASE AN OBLIGATION TO PAY OR TRANSMIT MONEY OR PROPERTY TO THE GOVERNMENT

KNOWINGLY MAKES, USES, OR CAUSES TO BE MADE OR USED, A FALSE RECORD OR STATEMENT TO GET A FALSE OR FRAUDULENT CLAIM PAID OR APPROVED BY THE GOVERNMENT

HAS POSSESSION, CUSTODY, OR CONTROL OF PROPERTY OR MONEY USED, OR TO BE USED, BY THE GOVERNMENT, AND WILLFULLY CONCEALS THE PROPERTY, OR DELIVERS LESS PROPERTY THAN THE AMOUNT FOR WHICH THEY RECEIVE A CERTIFICATE OR RECEIPT

KNOWINGLY BUYS, OR RECEIVES A PLEDGE OF AN OBLIGATION OR DEBT, PUBLIC PROPERTY FROM AN OFFICER OR EMPLOYEE OF THE GOVERNMENT OR A MEMBER OF THE ARMED FORCES WHO LAWFULLY MAY NOT SELL OR PLEDGE THE PROPERTY.

False Claims Act

- -There are civil penalties of no less than $11,181 and no more than $22,363 PLUS three times the amount of damages the Government sustains because of the act of the person
- There is Whistleblower protection under the False Claim Act
  - An employee must reasonably believe they're reporting a violation of the law.
  - An employer cannot discharge, demote, suspend, harass or in any manner discriminate against the employee for whistleblowing.

- Call our Fraud and Abuse Hotline at 1-888-343-4221.
- Call the Division of TennCare from anywhere in Tennessee at 1-800-433-3982.
- Log on to https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html to complete an online form or to download a form to mail or fax to the State of Tennessee.

*** Whistleblower – An employee who discloses suspected fraud or abuse by their employer to a government or law enforcement agency*

CREDENTIALING

Credentialing

- Beginning October 1, 2021
  - All New IDD LTSS Providers wishing to join the ECF CHOICES and DIDD network will apply and credential through DIDD
  - The DIDD Process will consist of a Desk Review vs. an onsite visit.
  - Providers will be required to submit licenses, insurance, Policies and Procedures, etc.

- All protocols including the credentialing protocol can be found on the TennCare Protocol Webpage, https://www.tn.gov/tenncare/long-term-services-supports/partners-program-updates/ltss-protocols.html

CREDENTIALING

- Currently and until notification is received from TennCare and DIDD, current ECF CHOICES Providers will continue to follow the MCO Recredentialing process. This includes an onsite review of P&P, employee files and background checks utilizing our Joint MCO Site visit Tool.

- Upon notification from the state regarding changes is current provider recredentialing, the MCOs will collaborate with DIDD to outreach to providers, facilitate trainings and communicate updates to protocols.

- Processes for CHOICES providers will not change. CHOICES Providers will continue to be credentialed and recredentialed utilizing the current Joint MCO site visit tool.

ISC PROVIDER TRAINING

ISC PROVIDER TRAINING

- For Independent Support Coordination providers, the MCO shall provide training and education regarding the MCOs physical and behavioral health benefits and management processes, including expectations regarding collaboration with the MCO 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.

ONGOING PROVIDER TRAINING

ONGOING PROVIDER EDUCATION

- Joint MCO provider education
- Monthly education sessions on various topics
- Dates and times will be announced after October 1st

MCO CONTACT SUMMARY

- Amerigroup
  - Amy Eller, Amy.Eller@Amerigroup.com, Office phone: (615) 651-0479
  - Emily Goolsby, Emily.Goolsby@Amerigroup.com, Office phone: (423) 486-8716
  - TNLTSSPR@anthem.com

- BlueCare
  - Phyllis White, Phyllis_White@bcbst.com, Office phone: (615) 295-9680
  - Britney Douglas, Britney_Douglas@bcbst.com, Office phone: (615) 427-3782

- UnitedHealthcare
  - Deborah Stewart, deborah_b_stewart@uhc.com, Office phone: 615-493-9549, Cell phone: 615-542-5467
  - Faith Franklin, faith_franklin@uhc.com, Cell phone: 615-906-5261

QUESTIONS?