Wellpoint | Tennessee

Intellectual/Developmental Disabilities Managed Long Term Services and Supports Programs

Provider Manual Supplement

Wellpoint

833-731-2153 | provider.wellpoint.com/tn

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 **provider.wellpoint.com/tn/**. To request a free, printed copy of this manual, call Provider Services at **833-731-2154**.

If there is an inconsistency between the information contained in this manual and the agreement between you or your facility and Wellpoint, the agreement governs. In the event of a material change to the information contained in this manual, Wellpoint 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. Wellpoint may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including 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 Wellpoint 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 Wellpoint 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 Wellpoint provider manual at **https://provider.wellpoint.com/tn/** > **Resources** > **Policies, Guidelines and Manuals**. All requirements from the general Wellpoint 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. Wellpoint will work with the Department of Disability and Aging (DDA) and TennCare to support all members enrolled in ECF CHOICES, 1915(c) Waiver and ICF/IID Facilities. Wellpoint 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 people 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 support to experience inclusive community living.

CONTACT INFORMATION

Wellpoint website
https://www.provider.wellpoint.com/tennessee-provider/home
Our provider website, provider.wellpoint.com/tn, offers you a full complement of online tools including:
• Enhanced account management tools.
• Detailed eligibility lookup tool with downloadable panel listing.
• More comprehensive downloadable member listing tool.
• Easier authorization submission tool.

Wellpoint phone numbers

Please have your Wellpoint provider ID number and NPI number available when you call Provider Services, 833-731-2154. Listen carefully and follow the appropriate prompts.

Provider Services telephone	**833-731-2154**
Provider Services fax	**800-964-3627**
TRS users	**711**
Automated provider inquiry line for member eligibility	**833-731-2154** ○ Check claims status and eligibility. ○ Request interpreter services.
24-hour Nurse HelpLine	**English: 866-864-2544 (TRS 711)**
Member Services	**833-731-2153 (TTY 711)**
Behavioral Health Services	**833-731-2154**
Electronic Data Interchange (EDI) Hotline	**800-590-5745**
Electronic Data Interchange (EDI)	Contact Availity Client Services **800-282-4548**.
TennCare online services tcmisweb.tenncare.tn.gov/tcmis/tennessee/Security/logon.asp Providers and trading partners can: · Verify TennCare eligibility. · Upload or download HIPAA transactions. · Submit or inquire about pre-admission evaluation status. · Use the TennCare messaging system. Providers and partners who wish to use this online service must be a TN.gov subscriber. If you cannot verify an enrollee's eligibility via this online system, you should contact the enrollee's TennCare MCO. You may also	800-852-2683

contact TennCare Provider Services at the phone numbers to the right.	
TennCare Member Medical Appeals See also: tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html	800-878-3192
Fraud, Waste, and Abuse Reporting To report TennCare member fraud or abuse: To report TennCare provider fraud or abuse:	Member Fraud and Abuse: **800-433-3982** Or online https://www.tn.gov/finance/looking-for/fa-fraudinfo.html Provider Fraud and Abuse: **833-687-9611** or online https://www.tn.gov/finance/looking-for/fa-fraudinfo.html Or TBI Medicaid Fraud Control Division at **800-433-5454** or email at: TBI.MedicaidFraudTips@tn.gov
Availity client services	Available Monday through Friday, 5 a.m. to 5 p.m. Pacific time at 800-Availity (**800-282-4548**), excluding holidays Email questions to support@availity.com
TennCare Provider Operations Call Center	**800-852-2683**
Tennessee Carriers	**866-680-0633**
CareBridge Support	**844-482-0256** **tnevv@carebridgehealth.com**
Family Assistance Service Center	**866-311-4287**
EVV Assistance email box	tn1ltcevvcs@wellpoint.com
LTC Authorization email box	ltcprovreq@wellpoint.com
Enhanced HCBS – FMAP Communication	**tn.gov/tenncare/long-term-services-supports/enhanced-hcbs-fmap.html**
Availity Training	**The Learning Hub**

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://perlss.tenncare.tn.gov/externalreferral.**

If the member is unable to complete the referral tool independently or has no natural support to do so on their behalf, the member may call Wellpoint at **833-731-2153** 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 and/or
- Adults age 21 and older with I/DD living at home with family caregivers 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, unless otherwise specified by TennCare, 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.

An eligible adult age 21 and older who meets NF LOC may enroll in ECF CHOICES Group 5, so long as the person's needs can be safely and appropriately met in the community and at a cost that does not exceed the expenditure cap, including individuals with I/DD who have an aging caregiver. 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 5, if they meet eligibility criteria.

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

- Adults age 21 and older, unless otherwise specified by TennCare, 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. 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 6, if they meet eligibility criteria.

Intensive Behavioral Family Supports (Group 7)

Children under age 21 who live at home with family caregivers and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm, threaten the sustainability of the family living arrangement, and place the child at significant risk of placement outside the home (for example, State custody, hospitalization, residential treatment, incarceration). 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. People are usually in this group short-term. Once the person is stable in the community, they will move to a different benefit group that can safely meet their needs.

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. 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 individual 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. People are usually in this group short-term. Once the person is stable in the community, they will move to a different benefit group that can safely meet their needs

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 DDA.

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. 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 shall, for members enrolled in ECF CHOICES Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 or 8 who also have an expenditure cap based on the comparable cost of institutional care, 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 **or** 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
Enabling technology (up to $5,000 per calendar year of Assistive technology and Enabling technology combined)	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 – Exploration for Individualized Integrated Employment – Exploration for Self-Employment – Benefits counseling – Discovery – Situational observation and assessment – Job development plan or self-employment plan – Job development start-up 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-centered treatment, stabilization, and supports (IBFCTSS)				X	
Intensive behavioral community transition and stabilization services (IBCTSS)					X

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.

ECF CHOICES members may choose to participate in consumer direction of eligible ECF CHOICES HCBS and, at a minimum, hire, fire, and supervise workers of eligible ECF CHOICES HCBS. For more details, see the Consumer Direction section.

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 (that is, 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 shall not be eligible to receive short-term care in a NF or ICF/IID.

Wellpoint 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) DDA 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 DDA is required. Wellpoint will provide such notification to DDA within five (5) business days of the person's admission to the NF, or of knowledge of such admission if Wellpoint is not notified until after admission occurred.

Within fifteen (15) days of admission (or knowledge of the admission if Wellpoint is not notified until after the admission occurred), Wellpoint will work with the member (and his/her representative, as applicable) to develop and submit a transition plan to DDA for review and approval to help facilitate return to the community with the right supports as soon as appropriate. If additional time is needed to develop the transition plan, Wellpoint shall notify DDA of the reason for delay, and the projected timeframe for submission of the transition plan. If the member (or his/her health care representative) is unwilling to engage in transition planning, Wellpoint will continue to engage the member on each subsequent visit. Wellpoint 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 covered for ECF CHOICES Group 4, 5, and 6. 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 to receive Medicaid-reimbursed NF or ICF/IID services.

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. Wellpoint 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 ECF CHOICES Group 4, 5 or 6 (as applicable) is appropriate.

Wellpoint shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TennCare on a monthly basis a member-by member status for each Group 4, 5, or 6 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 4, 5, or 6 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF 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 stay, Wellpoint shall include explanation regarding why the benefit limit has been exceeded, and specific actions Wellpoint is taking to facilitate discharge to the community including the anticipated timeline.

Electronic Visit Verification System

The Electronic Visit Verification (EVV) System is an electronic system used to monitor member receipt and utilization of certain ECF CHOICES services. The EVV system has the ability to log the arrival and departure of the worker through the use of GPS.

The system acts as verification that services are being performed within the member's preferred schedule and approved location. EVV services must be billed via the approved EVV system.

All HCBS providers that contract with a managed care organization (MCO) and receive Medicaid funding to provide CHOICES and/or Employment and Community First (ECF) CHOICES services must effectively and accurately use an approved EVV method to record member visits (home or community).

To help ensure appropriate use of the EVV system, MCOs require all agencies to employ a dedicated EVV coordinator who manages the EVV database on a daily basis, including after hours and weekends. As part of their daily functions, this EVV coordinator must ensure that active workers are scheduled to complete every member visit that your agency has accepted to provide. If a visit will not occur as scheduled or at all, the EVV coordinator will need to make sure the appropriate steps are taken to cancel, reschedule, or document the reason the visit was missed. The EVV coordinator shall also be responsible for making sure that every staff member uses an approved EVV method to check-in and out of every visit they provide. The EVV coordinator should also provide retraining to the staff and escalate non-compliance to management to implement their process for addressing EVV noncompliance.

Effective August 1, 2025, TennCare, the Tennessee MCOs, and CareBridge are excited to partner on the implementation of an Open Electronic Visit Verification (EVV) Model for personal care services providers within Tennessee. Providers may choose to use CareBridge as the EVV system at no cost, or providers may choose to contract with a third-party EVV vendor. Providers who choose a third-party EVV vendor will be responsible for any costs associated with that solution. CareBridge will integrate with the provider's chosen EVV vendor at no cost.

To use the EVV system, workers check in using a method that captures GPS coordinates at the member's home promptly upon arrival. The worker may download the CareBridge EVV application to their Android or Apple smartphone at no charge, which may be used for checking in and out of a visit. This confirms the identity of the worker, as well as the arrival time and location. Or the worker 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 worker will check out using a GPS method, logging the departure time.

Providers should notify Wellpoint immediately by sending an email to the provider request mailbox at ltcprovreq@wellpoint.com when a member has been identified as having no method to check in/out. This includes if the worker is unable to use the mobile application for check in/out or the member receiving care does not have a phone the worker can use to check in/out. Wellpoint 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 quarterly basis.

For ECF CHOICES members, providers shall notify the member's support coordinator, in accordance with Wellpoint's processes, as expeditiously as warranted by the member's circumstances, of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services.

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

- Log the arrival and departure of the worker.
- Verify that services are being delivered at the correct location (for example, the member's home) and at the appropriate time.
- Verify the identity of the 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 that the worker delivering the service is authorized to deliver such services.
- In consultation with the member, 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. Schedules should be created prior to the date on which the service occurs.
- Initiate the backup plan if a worker does not arrive as scheduled. Provider should code the missed visit to reflect that the backup plan was initiated.
- Ensure late and missed visit information is recorded within the monthly template sent from Wellpoint's EVV team and return the completed template timely. Information from providers is shared in the state reporting and must be accurate. Steps to resolve late/missed visits and prevention should be detailed and followed.
- Generate claims for submission to Wellpoint.
- Manage overlapping visits if they occur.

Whether providers utilize the MCO EVV system or a third-party EVV system, the following expectations apply.

Member Information Management: Providers should verify and input additional member addresses and phone numbers based on their location as identified. Accurate information ensures services are tailored to a member's needs.

Scheduling Protocols: Providers will work directly with members to develop schedules. Providers must prioritize the members' preferred hours allotted within their care plan when developing schedules. Providers must verify that the established schedules do not overlap worker shifts.

Late and Missed Visit Monitoring: Providers should develop a plan to monitor late and missed visits to address service delays or potential service gaps. The plan must include escalation procedures to initiate back up plans to guarantee uninterrupted care to members. If providers are unable to deliver services to members, providers must notify the MCO to outline the issue and the proposed resolution.

EVV Compliance and Utilization: It is essential for providers to monitor EVV compliance and utilization to deliver services that align with the member's PCSP. Services must cover the specified amount, frequency, duration, and scope as outlined in their service schedule, to continuously meet the members' needs.

Addressing Unauthorized Visits: If visits occur outside of the established radius without proper authorization, providers must implement strategies to swiftly address these situations.

The following information is specific to providers utilizing third-party EVV systems.

Third-party EVV systems must include comprehensive functionalities including:

- Capturing of PC, PA, SHC, IHR, and Respite services
- Storing authorizations and capturing GPS data
- Recording worker arrival/departure times
- Identifying multiple visit clock-ins
- Ensuring services are delivered in the authorized location and in line with the person-centered service plan (PCSP)
- Verifying worker identities

Authorization Management: Providers utilizing a third-party EVV system should load and remove member authorizations as communicated from the MCO to prevent scheduling delays or completion of unauthorized visits.

EVV System Management: Providers utilizing a third-party EVV system must develop and implement a strategy to inform the MCO within 2 business days of any issues affecting the EVV system's functionality, along with a remediation plan detailing the timeframe and potential impact on claims.

Data Management and Submission: Providers utilizing a third-party EVV system must ensure timely submission of visit data to the MCO, aiming for submission within 24 hours post-visit. Additionally, worker social security information must be accurately recorded by the provider in the EVV system. Provider's data extractions sent to the MCO from the EVV system facilitate straightforward claim submissions.

Worker Notes: The EVV system may capture worker notes, providing valuable insights for service evaluation and improvement (if available).

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 that 90% (or more) of scheduled services submitted for payment have GPS coordinates attached. Provider compliance with appointment staffing will be monitored on an ongoing basis.

Manual Timesheet Audits

Wellpoint will conduct audits of manual visit timesheets, asking providers to submit specified timesheets by a given deadline. Wellpoint will then evaluate the timesheets for compliance. Providers who fail to submit the requested timesheets for the audit on time, or whose timesheets do not meet the required criteria, will be subject to a Corrective Action Plan.

Timesheet Requirements – Audit Elements:
• Name of the member receiving services
• Signature of the member or an authorized representative (digital/font and voice signatures are not permitted)
• Time services were rendered/duration of care — a.m./p.m. designation should be included
• Date services were rendered (MM/DD/YYYY)
• Tasks performed
• Name of worker performing services
• Standard timesheet includes the company name and/or logo

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 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 to be paid for the following scenarios:
- Late visits
- Missed visits
- Visits in which the length deviates from authorization
- No authorization on file for visit or matching appointment
- Split visits
- More than one worker per visit
- When no check-in/out is recorded for the member
- When a stored check-in/out needs to be attached to a visit

Manual visits are instances in which the worker does not utilize an approved check-in/out method for visits completed. Providers must require workers to submit a timesheet that meets the following criteria to document that services were rendered. Timesheets will be requested by Wellpoint for timesheet audits. Time sheets are required to contain the below items:

- Name of the member receiving services
- Signature of the member or an authorized representative. (digital/font and voice signatures are not permitted)
- Time services were rendered/duration of care — A.M./P.M. designation should be included
- Date services were rendered (MM/DD/YYYY)
- Tasks performed
- Name of worker performing services
- Standard timesheet includes the company name and/or logo

Any visit confirmed without use of EVV for clocking in or clocking out that is within the provider's control is considered noncompliant and manually confirmed. Wellpoint will measure manual visit 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-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. 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 that use the electronic visit verification (EVV) system and that bill for services on behalf of TennCare CHOICES and ECF CHOICES members are required to submit specific member information regarding the LMV.

Wellpoint 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 Wellpoint 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.

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 tn1ltcevvcs@wellpoint.com.
- Do not make changes to prefilled cells. Only complete the highlighted 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

Wellpoint 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
- Manual visit timesheet audit: Provider did not submit the requested manual visit timesheets by the deadline
- Manual visit timesheet audit percentage below compliance standard: 90 percent (timesheets submitted by the provider must comply with required elements)

Effective January 1, 2020, in accordance with the TennCare Contractor Risk Agreement (CRA), changes were made to the 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.

Effective January 1, 2020, in accordance with the TennCare CRA, updates were made 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 Wellpoint.
- **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 Wellpoint).

All the server hardware and software needed to run the CareBridge system is provided through multiple redundant data centers.

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. Wellpoint uses support coordination as the continuous process of:

- Assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals 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).
- 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 Coordinators:

- 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 (for example, 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 their 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.

Wellpoint 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. Wellpoint 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

Wellpoint 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. Wellpoint 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 their 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
- For members receiving the following employment services – exploration, discovery, situational observation and assessment, or job development plan or self-employment plan – the member's support coordinator will contact the member telephonically to re-assess service needs upon the completion of one of the above services within five (5) days of completion of the service (which shall be defined as the date the report, profile or plan is submitted) in order to initiate the next employment service that is needed

- Document and confirm the member's address and telephone numbers or appropriate alternative phone number(s) that is in the member's record is accurate, and assist the member in updating his or her address with TennCare or the Social Security Administration, if applicable.

- 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
- 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 for those in a provider owned or controlled setting, 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 Wellpoint 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, Wellpoint 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 physical or behavioral health and/or functional status
        - An event that significantly increases the perceived risk to a member, including but not limited to referrals for abuse, neglect, or exploitation
        - Loss of employment or change in employment status

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

Wellpoint 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 take appropriate action to address physical and behavioral health needs and 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 for persons in ECF CHOICES, referral for Behavioral Crisis Prevention, Intervention, and Stabilization Services if medically necessary.
For members with chronic physical conditions that require ongoing treatment who also have behavioral health needs, Wellpoint will encourage participation of both the member's physical health provider (PCP or specialist) and behavioral health provider in the assessment and individualized treatment plan development process as well as the ongoing provision of services. For ECF CHOICES members with behavioral health needs, the member's support coordinator will encourage participation of the member's behavioral health provider in the PCSP process and will incorporate relevant information from the member's behavioral health treatment plan in the member's PCSP. For any member with I/DD receiving Behavioral Crisis Prevention, Intervention, and Stabilization Services, the support coordinator will participate in coordination of services, and will ensure that the Crisis Prevention, Intervention and Stabilization Plan developed is incorporated into the PCSP, as appropriate.

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 their 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 (for example, 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 Wellpoint 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

ECF CHOICES group	Contact details
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	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 *(upon Money Follows the Person [MFP]* transition at the conclusion of his 365-day participation period)*	• 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:
	  ○ 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	• 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 *(with community living supports [CLS] housing, upon transition to CLS home)*	• Within 24 hours; telephone contact • Within 7 calendar days; face-to-face contact Members in ECF CHOICES Group 5 or 6 receiving community-based residential alternative services, including community living supports and community living supports-family model, shall also be contacted by their support coordinator either in person or via video conference each calendar month. Face-to-face visits in the member's place of residence shall occur at least quarterly (that is, the member's support coordinator must complete one face-to-face visit within ninety [90] calendar days of the previous face-to-face visit) to ensure that the PCSP is being followed and continues to meet the member's needs; unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's PCSP, based on a significant change in circumstances (see Section A.2.9.7.11.2.1.17). If the member's preference is for face-to-face visit, the support coordinator shall meet in person in accordance with the preference of the member.
Group 4	Members in ECF CHOICES Group 4 shall be contacted by their Support Coordinator in person or by telephone at least quarterly (that is, the member's support coordinator must complete each subsequent contact within ninety [90] calendar days of the previous contact). These members shall be contacted via videoconference and/or visited in their residence face-to-face by their Support Coordinator at least semi-annually (that is, within one hundred and eighty [180] calendar days of videoconference contact, the member's support coordinator must

ECF CHOICES group	Contact details
	complete a face-to-face visit, and within one hundred and eighty [180] calendar days of the face-to-face visit, a video contact will occur); unless more frequent contacts/visits and/or telephone contacts are 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. If the member's preference is for a face-to-face visit, the support coordinator shall meet in person in accordance with the preference of the member.
Group 5	Except as provided in A.2.9.7.11.4.3.13, members in ECF CHOICES Group 5, shall be contacted by their support coordinator in person or by telephone at least monthly (that is, the member's support coordinator must complete each subsequent contact within thirty [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 (that is, the member's support coordinator must complete each subsequent face-to-face visit within ninety [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.
Group 6	Members in ECF CHOICES Group 6 identified as low/moderate need shall be contacted by their support coordinator in person or by telephone at least monthly (that is, the member's support coordinator must complete one contact each month). These members shall be contacted via videoconference and/or visited in their residence for a face-to-face visit by their support coordinator at least quarterly (that is, within ninety [90] calendar days of videoconference contact, the member's support coordinator must complete a face-to-face visit and within ninety [90] calendar days of the face-to-face visit, a video contact will occur); unless more frequent contacts/visits and/or telephone contacts are 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. If the members preference is for face-to-face visit, the support coordinator shall meet in person in accordance with the preference of the member. 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 216 members with low to moderate need who have exceptional medical or behavioral needs), shall be contacted by their support coordinator either in person or via videoconference each month (that is, the member's support coordinator must complete one contact in person or by videoconference each calendar month). Face-to-face visits in the member's place of residence shall occur at least once per quarter (that is, the member's support coordinator must complete one face-to-face visit within ninety [90] calendar days from the previous face-to-face 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. If the members preference is for face-to-face visit, the Support Coordinator shall meet in person in accordance with the preference of the member.

ECF CHOICES group	Contact details
Group 7	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 (that is, 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 (that is, 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.
Group 8	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 (that is, 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 (that is, 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.

* 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 support provided by family members, as well as other natural support through paid services provided by us and other payer sources.

The person-centered planning process is directed by the member, or if applicable, the member and the member's authorized representative. 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 they are 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 (that is, 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 support 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, Wellpoint 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, Wellpoint 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.

Wellpoint 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.

Instances in which a member's signature is not required are limited to:
1) member-initiated schedule changes to the PCSP that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current PCSP for the member (however, all schedule changes must be member-initiated);
2) changes in the provider agency that will deliver services that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current PCSP for the member;
3) changes in the member's current address and phone number(s) or the phone number(s) or address that will be used to log visits into the EVV system;
4) the end of a member's participation in MFP at the conclusion of his/her 365-day participation period;
5) the completion of one employment service and the initiation of another one as the member progresses towards meeting individual employment goals established in the PCSP; or
6) instances as permitted pursuant to TennCare policies and protocols, including emergency circumstances where the member's health and safety necessitate service initiation prior to member or representative signature.
Documentation of such changes will be maintained in the member's records, including an attachment listing all of the member's current LTSS providers. Each time a change in the member's LTSS provider(s) occur(s), Wellpoint will be responsible for circulating an amended attachment listing the current, updated LTSS provider list to all providers on the attachment within five (5) business days of any such update.

The member's Support Coordinator/support coordination team will provide a copy of the member's completed PCSP including any updates, to the member, the member's representative, as applicable, the member's PCP, the member's community-based residential alternative provider, as applicable, and other providers authorized to deliver services to or for the benefit of the member. The member's Support Coordinator/support coordination team shall further require that:
(a) each individual or provider responsible for implementation of the plan of care or PCSP signs the plan of care or PCSP, as applicable, indicating they have reviewed the plan in its entirety, they understand the plan, and agree to provide the services as described and in accordance with the specific goals, preferences and needs of the member, as outlined in the plan of care or PCSP, as applicable and the comprehensive assessment; and
(b) each provider receives the fully completed comprehensive assessment and plan of care or PCSP, as applicable, at least two business days prior to the scheduled implementation of services and prior to any change in such services in order to ensure appropriate and timely training of provider staff.
Wellpoint will have mechanisms in place to ensure that such signatures and confirmation of each provider's agreement to provide services occurs within the timeframes specified, such that a delay in the initiation of services does not result. Electronic signatures will be accepted for providers who are not present during the support planning process or as needed to facilitate timely implementation, including updates to the PCSP, based on the member's needs. Electronic signatures should be captured on the plan of care or PCSP.

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.

Member Eligibility

Wellpoint will conduct outreach to remind members to provide TennCare with current contact information and when directed by TennCare to do so, will utilize templates and toolkits in various formats to encourage members to respond to TennCare's redetermination requests. Wellpoint will conduct outreach and ensure members enrolled in ECF CHOICES fully and timely complete and submit an annual renewal packet for eligibility redetermination, providing assistance as necessary. In addition, Wellpoint will be responsible for 1) assisting members who have significant disabilities and/or complex medical needs and who have been determined by TennCare to no longer qualify for Medicaid in any other eligibility category in applying for Katie Beckett Part A or qualifying in the Katie Beckett Continued Eligibility Group, as applicable, and in accordance with processes and timelines established by TennCare; 2) applying comparable cost of care requirements for children in the Katie Beckett Continued Eligibility Group in accordance with processes established by TennCare; and 3) for assisting families of members in the Katie Beckett Continued Eligibility Group plan and prepare for the child's transition to employment and community living with as much independence as possible upon becoming an adult, and in completing an application for Supplemental Security Income (SSI) when the member turns eighteen (18).

The member's support coordinator will inform each member of their eligibility end date and educate members regarding the importance of maintaining TennCare ECF CHOICES eligibility, that eligibility must be redetermined at least once a year, and that members receiving ECF CHOICES HCBS, may be contacted by TennCare or its designee to offer assistance with the redetermination process (e.g., collecting appropriate documentation and completing the necessary forms), when such process has not been completed timely and the member is at risk of losing eligibility.

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.

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. Self-direction of health care task is an option for individuals participating in consumer direction to direct and supervise a paid worker delivering eligible ECF 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. For members in Group 7, Community Transportation is the only eligible HCBS for Consumer Direction.

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 their care, they 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 their behalf. The member must make arrangements for the provision of needed care and does not have the option of going without needed services.

Member Care

Wellpoint 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.

Quality Monitoring

Wellpoint 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 Wellpoint Provider Relations and quality teams.

All DDA quality monitoring surveys, including the initial consultative survey and subsequent recurrent surveys, are intended to encourage, promote, and recognize quality within each provider organization. As such, the surveys are intended to be a positive, affirming, and constructive experience for providers; recognizing what they are doing that signifies quality and encouraging, as well as advising, them on how to further increase quality practices and outcomes. The quality monitoring surveys are focused on recognizing quality and do not promote a deficit-driven or policing culture but instead focus on measuring the quality of services based on the perspective of the people receiving services and the provider's practices.

Each indicator is scored on achievement levels:
o Needs development
o Additional refinement needed
o Met expectations
o Exceeds expectations
o Sets a new standard of performance
o Not applicable - N/A
Wellpoint will utilize the information obtained through DDA Quality Monitoring surveys in determining the appropriate course of action to support and/or counsel each provider in the ECF CHOICES network,

The following list outlines services for quality monitoring (for all HCBS services):

- Behavior Services
- Behavior Respite
- Career Advancement
- CHOICES Community Living Supports (CLS/CLS-FM)
- Community Participation Supports
- Co-Worker Supports
- Discovery, Exploration, Job Development (Pre-Employment Services)
- Employment and Community First (ECF) CHOICES CLS/CLS-FM
- ECF CHOICES Independent Living Supports (ILST)
- ECF CHOICES Personal Assistance (PA)
- ECF CHOICES Supportive Home Care (SHC)
- ECF CHOICES Community Integration Support Services (CISS)
- Enabling Technology
- Facility Based Day
- Family Model Residential Support
- Individual Transportation Services
- Integrated Employment Path Service (PATH Service)
- Intermittent Employment and Community Integration Wrap-Around Support
- Job Coaching for Individualized Integrated, Competitive Employment
- Job Coaching for Self-Employment
- Medical Residential (Includes Medical Supported Living)
- Non-Residential Homebound Support Service (+Special Needs Adjustment Residential Homebound)
- Nursing
- Nutrition
- Occupational Therapy
- Orientation and Mobility Supports
- Physical Therapy
- Personal Assistance (1915(c))
- Residential Habilitation
- Respite
- Self-Employment Start Up
- Semi-Independent Living
- Speech, Language and Hearing
- Support Coordination
- Supported Employment
- Supported Employment – Small Group Supports
- Supported Living
-

Consultative and Recurrent Survey Process

The goal of the Consultative Survey Process is to afford providers an opportunity to become familiar with the Quality Monitoring Process and the Quality Topics 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 Quality Monitoring Surveys, including the initial Consultative Survey and subsequent Recurrent Surveys, are intended to encourage, promote, and recognize quality within each provider organization. As such, the Surveys are intended to be a positive, affirming, and constructive experience for providers; recognizing what they are doing that signifies quality and encouraging, as well as advising, them on how to further increase quality practices and outcomes. The Quality Monitoring Surveys are focused on recognizing quality and do not promote a deficit-driven or policing culture but instead focus on measuring the quality of services based on the perspective of the people receiving services and the provider's practices.

Information regarding the Quality Assurance and Monitoring survey process is on the DDA website at **https://tn.gov/disability-and-aging/about-us/divisions/office-of-quality-management/quality-assurance.html.**

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 backup 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 their PCSP until other services are arranged and provided that are of acceptable and appropriate quality**.**

The provider shall routinely monitor and evaluate the workforce to address shortages that affect service initiation. Provider shall address and work through employment barriers created by bias and discrimination based on class, race, color, national origin, age, disability, creed, religion, sex, and other protected statuses.

The Provider Workforce Development Director is available to support providers experiencing workforce development challenges with a myriad of interventions such as training, job fairs, technical assistance and more. Provider training supports are available for staff upskilling, service expansion, and credentialing on a first come, first served basis. For support, email workforcedevelopment@wellpoint.com.

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 Wellpoint, 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, including registry and exclusion checks,
- Fraud, Waste & Abuse reporting protocols,
- Prevention of duplicative payments,
- Monitoring of missed visits.

Employment Services Reports

All LTSS employment report templates are available for download at www.tn.gov/tenncare/long-term-services-supports/documents.html. All providers of employment services are required to utilize the new templates for outcome-based employment services that started on May 1, 2024, or later. Those required templates include:

- Exploration- individual
- Exploration- Self Employment
- Benefits counseling
- Discovery — individual
- Situational observation and assessment — individual
- Job development plan
- Self-employment plan
- Job development start-up (all 3 phases)
- Self-employment start-up (all 3 phases)
- Career advancement (both phases)

There are also recommended templates for all non-outcome-based employment services. While the use of these specific templates is not required, they are strongly encouraged. These templates include the required components for service justification and continuation. Regardless of format, providers are required to submit documentation of these required components to the MCO Care/Support Coordinator each month. Those services include:

- Co-Worker Supports (Agreement and Service Log)
- Integrated Employment Path Service (Service Log)
- Job Coaching (Wage and Self Employment)
- Fading Plan for Job Coaching (required prior to re-authorization of the service)
- Supported Employment Small Group (Service Log)

Initial and Ongoing Staff Training Requirements

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

- Orientation to the population that staff will support (for example, 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
    - Individual-specific training on services specific to each person they will support;
    - 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)

Training Alignment: ECF CHOICES and 1915(c) LMS Requirements for Direct Support Professionals (DSP)

The Division of TennCare and Department of Disability and Aging (DDA) continue to work toward an aligned system for all Medicaid long-term services and supports (LTSS) programs for people with intellectual and developmental disabilities (I/DD). A workgroup consisting of TennCare, DDA, and Tennessee Community Organizations (TNCO) developed a temporary alignment for current Pre and Early (30-60 day) training requirements available in the TNDIDD Relias Learning Management System (LMS) for ECF CHOICES and 1915(c) HCBS. The training grid for Pre-Service (30 day) and Early Service (60 day) for all DSPs is available on the DDA training webpage under the Training Requirements Tab: https://tn.gov/disability-and-aging/about-us/divisions/training.html.The aligned training requirements were rolled out February 1, 2024, with a 90-day grace period. Agencies were required to implement the new DSP requirements between February 1 and April 30, 2024. Please refer to the DDA training webpage for the specific training requirements for provider staff categories.

Training Alignment: ECF CHOICES and 1915(c) Job Shadow Requirements and Recommendations

New direct support professionals (DSPs) thrive in an organization when they quickly connect to the organization and their co-workers. Providing an effective orientation/onboarding for new employees enables DSPs to know what is expected of them and feel supported in their new roles. This might be called "job shadowing." Failing to properly onboard employees results in poor performance and unnecessarily high turnover. Recently, DDA conducted a "World Café" in each region, in which DSP responses requested better onboarding and/or job shadowing opportunities including better explanations and showcasing examples of what the job entails. Best practices include a plan for the first 6 months of a new employee's orientation and performance expectations.

Effective onboarding can provide the opportunity for experienced DSPs to tell and show new employees what is expected of them on the job and how to do these tasks.

TennCare collaborated with TNCO and the University of Minnesota (UMN) to address workforce challenges for DSPs in Tennessee. As part of this Workforce Initiative, the Realistic Job Preview (RJP) video was developed and can be used during the interview and/or onboarding process. Additionally, this Workforce Initiative published the DSP Workforce Toolkit which is a collection of evidence-based tools and strategies that assist organizations in finding, choosing, and keeping quality DSPs.

Onboarding shall include orientation, touring, training, coaching, shadowing, and mentoring within a specified timeframe. Each provider must have policies and procedures in place that reflect these requirements and how the requirements will be tracked. Policies must contain information as to how the agency will track the following:

1. Agency Specific Training: This is to be completed in the first 30 days. This should consist of, but is not limited to: Vision, Mission, organizational structure, customer service, policies, tour of facilities to meet both other staff and those we support.
2. Training specific to the person(s) the staff will support – Each organization/agency provides a variety of services which can vary from agency to agency. However, we know that person-centered thinking, planning, and practices are top priorities for all organizations/agencies. Prior to working alone, the DSP will have training on all services specific to each person they will support. These trainings will be tailored for the person supported, therefore, cover the specific services the DSP will provide. Organizations/Agencies may use their own checklist (paper version) to ensure workers complete the individual training specific to the person supported or track it within the LMS (Live Events> External Learning> Skills Checklists) to keep track of this requirement.

Additional Information/Tips for policies:

1. Explain how the Agency Specific Training will look and how it will be tracked.
2. Explain how the Individual Specific Training will look and how it will be tracked. This should include information such as: tailored to the individual, training per service the person(s) supported receive, informational setting training per service categories, job shadowing (that is,: minimum of 2 hours per service), mentoring (on going), detailed description of the skills check list including format (paper, LMS Live Event/Skills Checklist) and information collected for credentialing and QA purposes. Agencies do have the option to include all services provided during the new hire process.
3. Policy shall include the process for training a seasoned DSP when there are changes in an individual's support plan for the person they support and/or when DSP supports a new person. Additionally, the policy shall include information as to how the DSP will be trained tailored to the individual and any new services they will be providing.

4. DSPs should receive training specific to the person(s) from an experienced DSP, manager, lead supervisor, or house lead.

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.

Staff Qualifications for Employment Providers

Specific training courses are identified by staff category, which is defined by functional responsibilities, on the DDA training webpage, **https://www.tn.gov/disability-and-aging/about-us/divisions/training.html**, under *DDA Training Requirements for Provider Staff Categories*. Training course titles may change as content is modified to reflect new CMS requirements or changes to best practice.
Employment staff core requirements, qualifications, training and continuing education (if applicable) requirements are found on the DDA training webpage, under *Employment Staff Training Requirements – All HCBS Programs.* For each employment service, TennCare has established the type of staff certification that is required to provide the service.

There are core qualifications that all staff providing employment services must meet.
These requirements have been specifically defined to best position employment services providers to support members with achieving their employment goals.

Any staff providing employment services must meet the following qualifications:

- 18 years of age or older
- Can 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
- Has GED or high school diploma
- Passes criminal background checks, and is not listed on the TN Department of Health (TNDOH) Abuse Registry or TN Sexual Offenders Registry.
- If driving is involved in job duties, has valid driver's license and automobile liability insurance
    - If using own vehicle to transport members is involved in job duties, 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 - found at https://www.tn.gov/disability-and-aging/about-us/divisions/training.html**,** *DDA Training Requirements for Provider Staff Categories*.
- Has information/training specific to person(s) being served
- Has six months or more experience of working with individuals with ID and/or DD, where the work included teaching skills and/or tasks, preferably in an employment setting.

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 non-disability-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 Wellpoint executing a provider agreement with a provider seeking Medicaid reimbursement for ECF CHOICES, Wellpoint 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 Wellpoint. When a provider has returned their self-assessment indicating their full compliance with the HCBS Settings Rule, Wellpoint 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, Wellpoint 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, Wellpoint 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.

Department of Disability and Aging (DDA) is the credentialing and recredentialing entity for all Katie Beckett (KB) Services- Part A and B (collectively “provider services”), 1915(c), Employment and Community First (ECF) CHOICES, ECF Providers who also provide CHOICES Waiver Services and CHOICES Providers who also provide 1915(c), and/ or Katie Beckett services. DDA assesses providers’ compliance with HCBS Settings during the credentialing and recredentialing process.

In accordance with the *Contractor Risk Agreement*, Wellpoint will conduct ongoing provider education training and technical assistance on the HCBS Settings Rule, as deemed necessary by TennCare.

The Wellpoint 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 Wellpoint or nonpayment by the state to Wellpoint. Further, providers shall not charge members for missed appointments.

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

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 Wellpoint 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 Wellpoint 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, they 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 Wellpoint 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 Wellpoint 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 Wellpoint or appropriate denial made by Wellpoint (or, if applicable, payment by Wellpoint 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 Wellpoint 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, Wellpoint 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 Wellpoint, Wellpoint 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 for services or a change in the member's PCSP, please send the Provider Authorization Request Form to ltcprovreq@wellpoint.com and include the following information.

- Provider name and Wellpoint provider ID
- Member's name/Wellpoint subscriber ID
- Dates of service/ service type/unit amount requested

These requests will be sent to the member's support coordinator, who will take action and determine if such an 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. To update contact information to receive information via DocuSign, providers should email ltcprovreq@wellpoint.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 Wellpoint to ensure proper communication is possible. To maintain current records, please provide the email address (es) you wish to have on file with Wellpoint to ltcprovreq@wellpoint.com.

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

Providers should verify member eligibility before providing services. Wellpoint provides access to an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and referral authorization status. Visit provider.wellpoint.com/tn/. Wellpoint is unable to reimburse claims for dates of service when a member is not eligible for Medicaid and/or ECF CHOICES, CHOICES, or 1915(c) services.

If you are unable to access the internet, you may receive claims, eligibility and referral authorization status over the telephone at any time by calling the toll-free automated Provider Inquiry Line at **833-731-2154**.

Electronic Visit Verification System
Claims for specified HCBS services must be submitted 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 Wellpoint 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 **800-590-5745**.

Claims status

Providers can check the status of claims at provider.wellpoint.com/tn or call Provider Services at **833-731-2154** to check claims status. Providers should also use the claims status information available for claims that were electronically submitted through a clearinghouse for information on accepted and rejected claims by reviewing the electronic response reports.

Wellpoint supports the ability to obtain real time claim status information using the 276/277 transaction through Smart Data Solutions. Providers interested in utilizing this functionality can contact Smart Data Solutions directly at **855-297-4436** to obtain additional information.

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 document's resolution of the claim. For cases of retroactive eligibility, the time frames for filing a

claim will begin on the date that Wellpoint 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 Wellpoint receives notification from TennCare of the member's eligibility/enrollment. Paper claims must be submitted to the following address:

Wellpoint 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 the term ICD-10 is often used 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

Wellpoint 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 Wellpoint. 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. Wellpoint will not pay any claims submitted using noncompliant billing codes.

Wellpoint 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 Wellpoint 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 Wellpoint 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 Wellpoint, 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 **provider.wellpoint.com/tn/**, or the telephonic Provider Inquiry Line at **833-731-2154**. If the claim is not on file with Wellpoint, 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 Wellpoint
- 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 the billing provider or the vendor of the billing provider used to submit the claim.

Wellpoint 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 Wellpoint's provider website at **provider.wellpoint.com/tn/** or call the automated Provider Inquiry Line at **833-731-2154** 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 Essentials.

Provider Claim Payment Disputes and Independent Review

- For information on provider payment disputes and independent reviews, please refer to the general Wellpoint provider manual found at **provider.wellpoint.com/tn/**.

Electronic Data Interchange Trading Partner

Trading partners connect with Availity's EDI gateway to send and receive EDI transmissions. A trading partner can be a provider organization using software to submit direct transmissions, billing company or a clearinghouse vendor.

To become an EDI trading partner visit **availity.com**. Login if already an Availity user, choose **My providers < Transaction Enrollment** or choose **Register** if new to Availity.

Payer ID

Claim Payer ID: WLPNT

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID. Please contact Availity Client Services with any questions at **800-Availity (282-4548**).

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these easy steps:

1. Log in to Availity **https://apps.availity.com/availity/web/public.elegant.login**
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**
4. Select Health Plan (Payer) Wellpoint (Payer ID: WLPNT)

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Electronic Funds Transfer (EFT)
Electronic claims payment through EFT is a secure and fast way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use enrollsafe.payeehub.org to register and manage EFT account changes.

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 Wellpoint 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 Wellpoint has submitted a request to do so to TennCare and obtained prior written approval from TennCare.

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. The Statewide 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.

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. The CAC 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 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.

1. 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).
2. A person discharged from the Harold Jordan Center (HJC) following a stay of at least ninety (90) days, or
3. A member transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, or January 1, 2020, because they were 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 DDA 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: **tn.gov/tenncare/long-term-services-supports/documents.html.**

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

- 1915(c) Consumer Direction Protocol
- Aligned Background Check Protocol
- Community Informed Choice Process (CICP) for ICF/IID Protocol
- Credentialing Protocol
- Dental Protocol
- Dignity of Choice Protocol
- Employment Informed Choice in 1915(c) Waivers Protocol
- Enabling Technology Utilization Protocol
- One System REM Protocol
- Provider Recredentialing Protocol
- REM Protocol Definitions

For 1915(c) Waiver providers, please email at DDA_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 **tn.gov/content/dam/tn/**.

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 DDA's Member Services at: West TN Regional Office **866-372-5709**; Middle TN Regional Office **800-654-4839**; East TN Regional Office **888-531-9876** to speak to someone about their benefits.

DDA 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, DDA 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 DDA Investigations Unit. Please submit correspondence to Customer-Focused Service at DDA.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.

Customer-Focused Service Reporting: **833-696-2089** (DDA.CustomerFocusedService@tn.gov)

The following are additional Wellpoint resources you may find useful:

- Provider Services fax: **800-964-3627**
- Provider Services: **833-731-2154**
- Family Assistance Service Center: **866-311-4287**
- Member Fraud and Abuse: **800-433-3982** or online https://www.tn.gov/finance/looking-for/fa-fraudinfo.html
- Provider Fraud and Abuse: **833-687-9611** or online https://www.tn.gov/finance/looking-for/fa-fraudinfo.html
- Or TBI Medicaid Fraud Control Division at **800-433-5454** or email at: TBI.MedicaidFraudTips@tn.gov

Members can also contact the 24-hour Wellpoint Nurse HelpLine at **866-864-2544 (TRS 711)** for:

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

MEMBER ELIGIBILITY AND ENROLLMENT

The Statewide Waiver, CAC Waiver and Self-Determination Waiver are closed to new referrals with minor exceptions.

Wellpoint will conduct outreach to remind members to provide TennCare with current contact information and when directed by TennCare to do so, will utilize templates and toolkits in various formats to encourage members to respond to TennCare's redetermination requests. Wellpoint will conduct outreach and ensure members enrolled in the 1915(c) waivers fully and timely complete and submit an annual renewal packet for eligibility redetermination, providing assistance as necessary.

In addition, Wellpoint will be responsible for 1) assisting members who have significant disabilities and/or complex medical needs and who have been determined by TennCare to no longer qualify for Medicaid in any other eligibility category in applying for Katie Beckett Part A or qualifying in the Katie Beckett Continued Eligibility Group, as applicable, and in accordance with processes and timelines established by TennCare; 2) applying comparable cost of care requirements for children in the Katie Beckett Continued Eligibility Group in accordance with processes established by TennCare; and 3) for assisting families of members in the Katie Beckett Continued Eligibility Group plan and prepare for the child's transition to employment and community living with as much independence as possible upon becoming an adult, and in completing an application for Supplemental Security Income (SSI) when the member turns eighteen (18).

The member's Independent Support Coordinator or SD Case Manager will inform each member of his/her eligibility end date and educate members regarding the importance of maintaining 1915(c) waiver eligibility, that eligibility must be redetermined at least once a year, and that members receiving 1915(c) waiver HCBS may be contacted by TennCare or its designee to offer assistance with the redetermination process (e.g., collecting appropriate documentation and completing the necessary forms), when such process has not been completed timely and the member is at risk of losing eligibility.

Tennessee Family Support Program

The primary focus of the Family Support Program[1] (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 severe disabilities who choose to live with their families; and 3) adults with severe disabilities not supported by other residential programs funded by state or federal funds. For more information on eligibility criteria for enrollment see the Family Support Program guidelines, which are available online on DDA website at https://www.tn.gov/disability-and-aging/disability-aging-programs/family-support.html.

[1] The Family Support Program is a coordinated system of family support services administered by DDA 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-Benefits Counseling (initial Benefits Counseling limited to a maximum of 20 hours once every 730 days; supplementary Benefits Counseling limited to an additional 6 hours and authorized up to 3 times per year; PRN Benefits Counseling limited to a maximum of 8 hours per situation and authorized up to 4 times per year.	X	X	X
Supported Employment – Individual Exploration (Exploration for	X	X	X

Benefit	Self-Determination	Statewide	CAC
Individualized Integrated Employment and Exploration for Self-Employment) limited to 1 unit per 365 days.			
Supported Employment – Individual Discovery (limited to 1 unit per 1095 days.	X	X	X
Supported Employment Individual-Job Coaching (limited to actual need and cannot be billed for more hours than the individual has worked in a billing period; Stabilization and Monitoring is 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
Supported Employment Individual-Job Development (Job Development Plan/Self Employment Plan limited to 1 unit per 1,095 days; Job Development Start -Up/Self Employment Start-Up limited to 1 unit per 365 days.	X	X	X
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

Benefit	Self-Determination	Statewide	CAC
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) Individual Transportation Consumer Direction limited to $225 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
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 (for example, service recipient-specific training of	X	X	X

Benefit	Self-Determination	Statewide	CAC
caregivers; monitoring dietary compliance and food preparation) shall be further limited to a maximum of one visit per day)			
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
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

Wellpoint assists the ISCs and DDA case managers 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 Wellpoint upon turning twenty-one (21) years of age and the member also receives 1915(c) HCBS Waiver services, Wellpoint will work with DDA, and the 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, Wellpoint shall refer that member to TennCare for transition as appropriate.

During the development of the person-centered support plan, the Independent support coordinator or DDA case manager 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.

Service Definitions

Definitions for 1915(c) services are found on DDA's webpage, https://www.tn.gov/disability-and-aging/provider-information/service-definitions.html

Behavior Services information is found on DDA's webpage, https://www.tn.gov/disability-and-aging/about-us/divisions/clinical-services/behavior.html

Nursing Services information is found on DDA's webpage, https://www.tn.gov/disability-and-aging/about-us/divisions/clinical-services/nursing.html

Short Term Stay

In addition to the 1915(c) benefits 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 (that is, no more than ninety (90) days) in a nursing facility 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.

Wellpoint will review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF 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 (that is, NF level of care for a short-term NF 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)DDA has reviewed and approved the request prior to admission and the start of the short-term stay in a NF 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 DDA is required. Wellpoint shall provide such notification to DDA within five (5) business days of the person's admission to the NF, or of knowledge of such admission if the Wellpoint is not notified until after the admission occurred.
Within fifteen (15) days of admission (or knowledge of the admission if Wellpoint is not notified until after the admission occurred), Wellpoint shall work with the member (and their representative, as applicable) and the ISC or DDA Case Manager, as applicable, to develop and submit a transition plan to DDA for review and approval to help facilitate return to the community with the right supports as soon as appropriate. If additional time is needed to develop the transition plan, Wellpoint shall notify DDA of the reason for delay, and the projected timeframe for submission of the transition plan. If the member (or his/her health care representative) is unwilling to engage in transition planning, Wellpoint shall continue to engage the member on each subsequent visit. Wellpoint shall monitor all short-term NF 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 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, Wellpoint 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. Wellpoint shall monitor, on an ongoing basis, members utilizing the short-term NF 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 stay benefit, including but not limited to the name of each 1915(c) waiver member receiving short-term NF services, the NF in which they currently reside, the date of admission for short-term stay, the number of days of short-term NF 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 stay, the Wellpoint shall include explanation regarding why the benefit limit has been exceeded, and specific actions Wellpoint is taking to facilitate discharge to the community including the anticipated timeline.

Person-Centered Support Plan (PCSP)

For all 1915(c) waiver programs, the person-centered support plan (PCSP) for members is developed by the independent support coordinator (ISC) or DDA Case Manager (CM), as applicable, and the Circle of Support.

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

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 regarding 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 their own decision and participate in activities of their 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 (that is, 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 support 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 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" (**nasddds.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 their 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 their 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 their 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 their 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 individual ship of the COS at any time. Typically, the COS includes the member, their 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 their 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 DDA 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. DDA will refuse payment to the Provider for services billed to DDA that are beyond the level of services authorized by DDA through PCSPs or PCSP Amendments, exceed payment rates for these services or are not billed to DDA within the appropriate time frame after the delivery of services.

Wellpoint is unable to reimburse for claims for dates of service when a member is not eligible for Medicaid and/or ECF CHOICES, CHOICES, or 1915(c) services.

Independent Support Coordination and DDA Case Management

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 persons employed to render support coordination services (independent support coordinators or ISCs) receive effective guidance, mentoring, and training, including all training required by TennCare and DDA. 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 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 Wellpoint 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 DDA CM for SD 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 their 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 their 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 DDA CMs) 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 DDA 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.

Wellpoint shall require that all 1915(c) waiver Independent Support Coordination providers participate in education and training activities as required by Wellpoint to understand physical and behavioral health benefits, and collaborate with Wellpoint 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. Wellpoint 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 ISCs:
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 for filling positions and job interviews.
- There is sufficient staff to ensure that support coordination responsibilities are met, and each person's needs regarding support coordination services are satisfactorily met.

DDA Case Manager (CM)

A qualified individual employed by DDA 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 their care, they 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 (that is, 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 their behalf.

Independent support coordinators and DDA case managers 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.

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 DDA 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: **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, DDA 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; for example, 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 them.
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 (that is, 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, DDA Regional Office Title VI Coordinators, or DDA 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 DDA 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 DDA 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 DDA 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 strategies[5] listed below to help people make decisions that require informed consent.

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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 their 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 they communicate their preferences when making decisions. If the member has a 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 their 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 (for example, treatment providers) to understand that the person's consent can be withdrawn.
10. Do not infer that the person has given consent simply because they are 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 DDA 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, **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 or DDA, as applicable. 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 DDA 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 DDA website, https://www.tn.gov/disability-and-aging/licensing/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 a Wellpoint-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 DDA and DOH licensure requirements. The Adult Tuberculosis (TB) Risk Assessment and Screening Form is available online: tn.gov/content/dam/tn/disability-and-aging/documents/provider-information/guidance-and-policy/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 DDA 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 their employment.

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

1. 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.
2. 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.
3. 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 DDA 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 DDA 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. DDA 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 National Sex Offender Registry, Systems for Award Management (SAM), OIG's List of Excluded Individuals/Entities (LEIE), or TennCare Terminated Provider List (TTPL)

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 DDA 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 DDA guidance, as required for compliance.

Providers will notify Wellpoint, 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, Wellpoint will notify the independent support coordinator/DDA CM.

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, their 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, in-person, or telephone.

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 DDA training requirements. Also excluded from DDA 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 (for example, *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 DDA training webpage, **https://www.tn.gov/disability-and-aging/about-us/divisions/training.html***, DDA Training Requirements for Provider Staff Categories***.** 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 specified on the DDA training webpage, **https://www.tn.gov/disability-and-aging/about-us/divisions/training.html**, *DDA Training Requirements for Provider Staff Categories.* For quality monitoring purposes, timeframes are calculated from the employee's date of hire or appointment date, as designated by the agency.

Training Documentation

Providers may utilize web-based training or choose to complete training using the web-based training materials in a classroom setting. DDA'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 (for example, *CPR, First Aid, Medication Administration for Unlicensed Personnel*) with certification documentation and staff test scores.

Certificates issued by DDA 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 DDA web-based training course names and the documentation requirements, see the job specific information in this chapter and on DDA 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 DDA Personal Training Profile available on DDA website: **https://www.tn.gov/disability-and-aging/about-us/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 ensures 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. For additional resources, refer to the training requirements on DDA's training webpage**:**

https://www.tn.gov/disability-and-aging/about-us/divisions/training.html, *DDA Training Requirements for Provider Staff Categories.*

In addition to web-based training, DDA 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 DDA website: **https://www.tn.gov/disability-and-aging/about-us/divisions/training/regional-training-calendars.html**. 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, DDA 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.

Employment

Specific training courses are identified by staff category, which is defined by functional responsibilities, on the DDA training webpage, **https://www.tn.gov/disability-and-aging/about-us/divisions/training.html**, *DDA Training Requirements for Provider Staff Categories.* Training course titles may change as content is modified to reflect new CMS requirements or changes to best practice. Employment staff core requirements, qualifications, training, and continuing education (if applicable) requirements are found on the DDA training webpage, **https://www.tn.gov/disability-and-aging/about-us/divisions/training.html,** *Employment Staff Training Requirements – All HCBS Programs.*

There are core qualifications that all staff providing 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.

Any staff providing employment services must meet the following qualifications:

- 18 years of age or older
- Can 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
- Has GED or high school diploma (1915(c)
- Passes criminal background checks, and is not listed on the TN Department of Health (TNDOH) Abuse Registry or National Sexual Offenders Registry If driving is involved in job duties, has valid driver's license and automobile liability insurance:
- If using own vehicle to transport members is involved in job duties, appropriate insurance coverage for this purpose Completion of required training for all DSPs - found at **https://www.tn.gov/disability-and-aging/about-us/divisions/training.html,** *DDA Training Requirements for Provider Staff Categories*.
- Has information/training specific to person(s) being served.

- Has six months or more experience of working with individuals 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 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. The qualifications must be met prior to delivering employment services. Please, review the DDA training webpage, **https://www.tn.gov/disability-and-aging/about-us/divisions/training.html,** *Employment Staff Training Requirements – All HCBS Programs* for details regarding the job type and qualifications required to provide each specific employment service.

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 specified *below.*

Specific courses and timelines for completion are identified and outlined in the Enabling Technology Training Requirements for Staff Categories document available on DDA training webpage: **https://www.tn.gov/disability-and-aging/about-us/divisions/training.html***, DDA Training Requirements for Provider Staff Categories***.** 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 DDA electronic learning management (ELM) system.

Provider staff following the Enabling Technology training requirements must also complete all required trainings as outlined by DDA *Training Requirements for Provider Staff Categories* available on DDA 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 Utilization Protocol can be found on TennCare's LTSS Protocol 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 DDA's waiver programs. Providers who employ staff to administer medication are responsible for compliance under DDA 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: **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 DDA 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 DDA. Required elements of a medication safety policy are specified in DDA 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 their 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 DDA 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" (that is, 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, for example, neuroleptic malignant syndrome, and serotonin syndrome. 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: **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 their clinical judgement and standard of care. It is the responsibility of the provider agency to maintain documentation of the screening (for example, 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

The services for each member are facilitated by an ISC or a DDA 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 (that is private insurance or Medicare), and the 1915(c) Waiver, the TennCare and non-TennCare other coverage benefits shall be utilized first.

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, and social services, and should not be confused with activities provided through 1915(c) waiver Independent Support Coordination or DDA 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)

Wellpoint will collaborate with DDA in its quality monitoring of 1915(c) waiver HCBS. DDA Quality Monitoring shall include all 1915(c) waiver services as specified in the interagency agreement between TennCare and DDA. All DDA quality monitoring surveys, including the initial consultative survey and subsequent recurrent surveys, are intended to encourage, promote, and recognize quality within each provider organization. As such, the surveys are intended to be a positive, affirming, and constructive experience for providers; recognizing what they are doing that signifies quality and encouraging, as well as advising, them on how to further increase quality practices and outcomes. The quality monitoring surveys are focused on recognizing quality and do not promote a deficit-driven or policing culture but instead focus on measuring the quality of services based on the perspective of the people receiving services and the provider's practices.

Each indicator is scored on achievement levels:

o Needs development
o Additional refinement needed
o Met expectations
o Exceeds expectations
o Sets a new standard of performance
o Not applicable - N/A
Wellpoint will utilize the information obtained through DDA Quality Monitoring surveys in determining the appropriate course of action to support and/or counsel each provider in the ECF CHOICES network,

The following list outlines services for quality monitoring (for all HCBS services):

- Behavior Services
- Behavior Respite
- Career Advancement
- CHOICES Community Living Supports (CLS/CLS-FM)
- Community Participation Supports
- Co-Worker Supports
- Discovery, Exploration, Job Development (Pre-Employment Services)
- Employment and Community First (ECF) CHOICES CLS/CLS-FM
- ECF CHOICES Independent Living Supports (ILST)
- ECF CHOICES Personal Assistance (PA)
- ECF CHOICES Supportive Home Care (SHC)
- ECF CHOICES Community Integration Support Services (CISS)
- Enabling Technology
- Facility Based Day
- Family Model Residential Support
- Individual Transportation Services
- Integrated Employment Path Service (PATH Service)
- Intermittent Employment and Community Integration Wrap-Around Support
- Job Coaching for Individualized Integrated, Competitive Employment
- Job Coaching for Self-Employment
- Medical Residential (Includes Medical Supported Living)
- Non-Residential Homebound Support Service (+Special Needs Adjustment Residential Homebound)
- Nursing
- Nutrition
- Occupational Therapy
- Orientation and Mobility Supports
- Physical Therapy
- Personal Assistance (1915(c))
- Residential Habilitation
- Respite
- Self-Employment Start Up
- Semi-Independent Living
- Speech, Language and Hearing
- Support Coordination
- Supported Employment
- Supported Employment – Small Group Supports

- Supported Living

Consultative and Recurrent Survey Process

The goal of the Consultative Survey Process is to afford providers an opportunity to become familiar with the Quality Monitoring Process and the Quality Topics 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 Quality Monitoring Surveys, including the initial Consultative Survey and subsequent Recurrent Surveys, are intended to encourage, promote, and recognize quality within each provider organization. As such, the Surveys are intended to be a positive, affirming, and constructive experience for providers; recognizing what they are doing that signifies quality and encouraging, as well as advising, them on how to further increase quality practices and outcomes. The Quality Monitoring Surveys are focused on recognizing quality and do not promote a deficit-driven or policing culture but instead focus on measuring the quality of services based on the perspective of the people receiving services and the provider's practices.

The survey process for both Consultative and Recurrent Surveys includes a Pre-Survey process, Entrance, Survey week activities, Conciliation, Survey Exit, and Final Report issuance. Additional information regarding the Quality Assurance and Monitoring survey process is on the DDA website at https://www.tn.gov/disability-and-aging/about-us/divisions/office-of-quality-management/quality-assurance.html.

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 DDA 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 DDA's performance as the operational lead agency and to evaluate DDA and provider agency compliance with state and federal rules, regulations, and policies.

When DDA requests documentation to support a response to a TennCare finding, providers are required to provide such documentation to DDA 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 DDA 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 on the DDA website.
Remediation must occur at all levels of the system. Individual findings will require provider and/or DDA remediation actions. The requirement is to achieve remediation of individual findings within thirty (30) days of discovery. DDA will perform follow-up validation reviews involving a sample of individual remediation actions. DDA 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.

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 DDA and discussed with TennCare during monthly QM meetings (if applicable to waiver providers and/or persons). TennCare will monitor implementation of DDA 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 DDA 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 Monitoring (QM) 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.

Wellpoint will submit a Provider Service Notification report to the Deputy Director of Quality Management or designee of DDA by the 15th of each month. This report is to include all providers added to Wellpoint's 1115 and 1915(c) provider network in the previous month. This report is used to update the Provider Directory maintained by the DDA Quality Management Unit and each regional Quality Assurance (QA) team is notified of any new providers that are to be added to the list of providers contacted monthly in order to determine when services are initiated. Within six (6) months of a provider initiating services, but no sooner than three (3) months from the initiation of services, the Regional QA team will initiate the Consultative Survey process. On completion of the Consultative Survey, providers will be placed on the quality monitoring survey schedule completed every 12-18 months.

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. DDA will coordinate corrective action with Wellpoint.

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:
DDA, TennCare, or Wellpoint employees identifying the immediate jeopardy situation will contact the agency director or designee to provide verbal notice of the immediate jeopardy situation. DDA 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. DDA's employee identifying the immediate jeopardy situation or other DDA staff available will notify DDA's Regional Office Director or designee of the immediate jeopardy situation and forward a copy of the immediate jeopardy notice when completed. DDA'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. DDA's employee will send a copy of the immediate jeopardy notice to the person's ISC/CM. DDA's employee will ensure 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 DDA 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 DDA's website. Other provider agencies are required to conduct an annual survey, the results of which are reviewed during DDA Provider Performance Surveys. Development of the satisfaction survey is the agency's responsibility.

DDA contracts with an external entity to administer the annual People Talking to People (PTP) Survey. The current PTP survey format is available on DDA'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 DDA 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 reportable events 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 DDA 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 DDA Regional Death Review Committees for all unexpected and unexplained deaths. DDA policy 90.1.2 Death Reporting and Comprehensive Death Review is available on DDA 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, reportable event and investigation information, and RPST follow-up information. 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.
Wellpoint will participate in the monthly RQMC and SQMC meetings when surveys are reviewed, and recommendations are made to Wellpoint regarding what actions should be taken. If the issue identified affects multiple members supported, Wellpoint and DDA PST will complete the necessary follow-up which may include technical assistance. Upon completion of the follow-up DDA PST will send a summary including recommendations for any follow-up actions from Wellpoint. Any punitive actions against the provider such as sanctions will be determined and imposed by Wellpoint, after consultation with DDA.

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 DDA. The RPST also supports existing providers performing below acceptable standards in certain quality topics of the Quality Monitoring Survey. 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 DDA. DDA 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. A Provisional license is issued by DDA, DOH, or any other licensure entity.
3. Financial issues are identified that threaten the continued financial viability of the agency.
4. 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 Wellpoint by DDA as will information and results of any consultations.

[6] For additional information on how performance is scored, go to DDA's web site, Quality Assurance page

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 Wellpoint. 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 DDA at no cost. The provider also may choose to contract with an outside entity that is approved by DDA, 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 DDA or the external entity chosen.
2. If the provider selected is presently contracted with DDA, 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.

DDA Mandated Technical Assistance (MTA)

1. If DDA 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 developed 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 DDA and the Wellpoint, 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, and training on specific topics.
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 topics from the QM 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 QM Survey Tool. It is not a new QM 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; for example, change in director or senior management, and natural disasters, such as fire or tornado); 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 DDA's current EVV vendor. DDA will administer and monitor 1915(c) Waiver provider's EVV Compliance.

Billing and Claims Submission

The MCOs pay claims for dates of service beginning 7/1/24. The paying of claims is not tied to IDD Integration and not tied to a contract with the MCO or a provider agreement. 1915(c) agencies for the provision of 1915(c) services are still contracted with DDA, but MCOs pay the claims.

Effective July 1, 2024, 1915(c) providers continue to submit claims through Therap.

Wellpoint pays 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 DDA via Services-DDA_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 Wellpoint or nonpayment by the state to Wellpoint. Further, providers shall not charge members for missed appointments.

Patient Liability

TennCare will notify Wellpoint of any applicable patient liability amounts for I/DD MLTSS Programs via the eligibility/enrollment file. Members owing patient liability will pay that amount to Wellpoint. If the effective date is any time other than the first day of the month, Wellpoint 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.

Wellpoint delegates collection of patient liability for 1915(c) waiver members who reside in a CBRA (that is, 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.

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

Wellpoint 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.

Wellpoint will not collect patient liability that exceeds the cost of 1915(c) waiver benefits reimbursed by Wellpoint 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, Wellpoint may request to no longer provide long-term services and supports to the member.

Wellpoint will not waive or otherwise fail to establish and maintain processes for collection of patient liability in accordance with the Contractor Risk Agreement.

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 Wellpoint 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 Wellpoint 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, they 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 Wellpoint 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 Wellpoint 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 Wellpoint or appropriate denial made by Wellpoint (or, if applicable, payment by Wellpoint 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 Wellpoint 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, Wellpoint 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 Wellpoint, Wellpoint will refer the provider to the Tennessee Bureau of Investigation.

Provider Grievance and Appeals

Providers may access the Wellpoint Medicaid Provider Manual via the Wellpoint provider portal, **https://provider.wellpoint.com/tn/** > **Resources** > **Polices, Guidelines and Manuals** > **Medicaid provider manual**. Wellpoint's Provider Complaint Procedures are outlined within the Wellpoint Provider Manual for Medicaid Services.

Provider Responsibilities for Complaint Resolution[7]

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. DDA has a Complaints Coordinator at each Regional Office who assists with complaint resolution. Complaints are monitored via a DDA 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 DDA's Complaint Resolution System, its purpose, and the steps involved to access it. This information will identify both the provider and DDA 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 DDA Customer-Focused Services (CFS) Unit or other DDA representatives. The provider will provide the complainant with DDA CFS Unit contact information. Upon being contacted, the CFS Unit will engage DDA's Complaint Resolution System[3] 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 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 Wellpoint, the ISC and/or DDA CM 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 DDA CM to facilitate a seamless transition to alternate providers.

7 Reference DDA policy 10.2.8 Complaint Resolution System **tn.gov/content/dam/tn/didd/documents/policies/10/10.2.8%20-%20Complaint%20Resolution.pdf**

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 Wellpoint, the ISC and/or DDA CM, or as otherwise directed by Wellpoint, the ISC and/or DDA CM, which may exceed sixty (60) days from the date of notice to Wellpoint 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. Wellpoint shall clearly document 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, their conservator or guardian, and their support coordinator, no less than sixty (60) days prior to the proposed date of service or Provider Agreement termination;
- Obtain Wellpoint, the ISC and/or DDA CM'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 Wellpoint, the ISC and/or DDA CM 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 DDA, 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 their 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 DDA in accordance with DDA 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 DDA 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.

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

Wellpoint 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 (for example, 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 they fully understand the full array of community-based options available to meet their needs, having been fully informed, affirmatively chooses the institutional placement.

Wellpoint 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 Wellpoint 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 ECF CHOICES or CHOICES which shall include (but is not limited to) timely notification to TennCare; and
- At a minimum, Wellpoint 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.

Wellpoint 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 — that is, 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

Wellpoint 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.

Wellpoint 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 their 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 (that is, 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 (that is, 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 Wellpoint when a person is discharged from the facility.

BILLING AND CLAIMS SUBMISSION

Electronic Submission

The MCOs pay claims for dates of service beginning July 1, 2024. The payment of claims is not tied to IDD Integration and not tied to a contract with the MCO or a provider agreement. ICF/IID agencies for the provision of ICF/IID services are still contracted with DDA, but MCOs pay the claims. Wellpoint pays these claims as outlined in the claim's adjudication process.

Effective July 1, 2024, Public ICF/IID providers continue to submit claims through Therap. Private ICF/IDD providers submit claims directly to the member's MCO.

Wellpoint 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 Wellpoint receives notification from TennCare of the member's eligibility/enrollment.

Availity is Wellpoint's designated Electronic Data Interchange (EDI) gateway. 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 **availity.com** and select **Register**. If you have any questions or concerns, please contact Availity at **800-AVAILITY (800-282-4548)**.
- Availity — Payer ID TNIDD; Phone: **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 **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 **800-AVAILITY (800-282-4548)**.

It is Wellpoint's priority to deliver a smooth transition of submission of ICF/IID services to Availity for our EDI services. If you have questions, please contact your Provider Relations representative or Provider Services at **833-731-2154** .

Electronic Data Interchange Trading Partner

Trading partners connects with Availity's EDI gateway to send and receive EDI transmissions. A trading partner can be a provider organization using software to submit direct transmissions, billing company or a clearinghouse vendor.

To become an EDI trading partner visit **availity.com**.
Login if already an Availity user, choose **My providers < Transaction Enrollment** or choose **Register** if new to Availity.

Payer ID
Claim Payer ID: TNIDD

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these easy steps:

1. Log in to Availity **https://apps.availity.com/availity/web/public.elegant.login**
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**
4. **Select Health Plan (Payer) WELLPOINT (Payer ID: WLPNT)**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs. Please contact Availity Client Services with any questions at **800-Availity (282-4548**).

Electronic Funds Transfer (EFT)
Electronic claims payment through EFT is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use enrollsafe.payeehub.org to register and manage EFT account changes.

Electronic Submission

Wellpoint 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.

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It is Wellpoint's 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 **833-731-2154**.

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 (that is, 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 DDA.
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 DDA 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 Wellpoint 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 Wellpoint for review and approval, and monitored by Wellpoint on an ongoing basis to ensure that it is implemented and that utilization of ICF/IID services continues to be appropriate for each of Wellpoint's members served in the facility.

Contact Information

For Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), please call Wellpoint Provider Services at **833-731-2154** 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 Wellpoint Member Services at **833-731-2153** (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 at **866-864-2544 (TRS 711)** for:

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

Patient Liability in an ICF/IID

Wellpoint 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 their patient liability and for whom the ICF/IID can demonstrate to the Wellpoint that it has made a good faith effort to collect payment.

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

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

BACKGROUND CHECK PROCESSES FOR 1915(C) WAIVER, KATIE BECKETT, EMPLOYMENT AND COMMUNITY FIRST CHOICES, AND CHOICES PROVIDERS

As provided fully in the TennCare protocol, "*Background Check Processes for 1915(C) Waiver, Katie Beckett, Employment and Community First CHOICES and CHOICES Providers*", providers of 1915(c) Waiver, Katie Beckett, Employment and Community First (ECF) and CHOICES services (collectively "HCBS" or "providers") are required to:
(1) have policies and processes concerning criminal background checks, including registry checks, for employees, subcontractors, and volunteers, in the manner outlined below;
(2) conduct all required criminal background checks, including registry checks, in the manner outlined below; and
(3) have policies and processes concerning individualized assessments for applicants for employment who have criminal backgrounds conducted.
Managed Care Organizations (MCOs) are required to verify that providers meet these three requirements. The Department of Disability and Aging (DDA) will provide oversight and monitoring for the 1915(c), Katie Beckett, CHOICES Community Living Supports (CLS)/CLS-Family Model (FM), and ECF providers. The MCOs will provide oversight and monitoring for all other CHOICES providers.

For CHOICES providers, a Background Check Protocol Roster is required to be used. Providers of 1915(c) Waiver, Katie Beckett, CHOICES CLS/CLS-FM, and ECF services have the option to use the Roster.

Individuals Subject to Criminal Background Check and Registry Check Requirements

Pursuant to state and federal law, there are three groups of individuals who are subject to the criminal background check and registry check requirements of this Protocol in relation to HCBS providers:

1. Employees, subcontractors, and volunteers who will be in a position that involves having **direct contact** with, or direct responsibility for, members receiving services.

2. Employees, subcontractors, and volunteers who will only have **incidental contact** with members receiving services.

3. Employees, subcontractors, and volunteers who will **not** have either direct or incidental contact.

Providers of HCBS are responsible for conducting registry checks as outlined below for **all** employees, subcontractors, and volunteers. However, depending on which of the three groups [direct contact, incidental contact or neither] applies to the employee, subcontractor, or volunteer, the HCBS provider will comply with all requirements established in Title 52 for obtaining a criminal background check and/or fingerprint check from the Tennessee Bureau of Investigation or, as an alternative, a criminal background check from a state licensed private investigation company.

Definitions:

Volunteer- For purposes of this protocol, a volunteer is an individual, unrelated to the member, who is performing unpaid services for the member. Volunteer does not include natural supports such as relatives or

friends of the member who seek to take the member on community outings or visit the member in his or her residence for companionship.

Direct Contact- For purposes of this protocol, an employee, subcontractor, or volunteer is considered to be in a position that involves direct contact with a person receiving services if the employee, subcontractor, or volunteer is supporting the person in the performance of personal care duties or providing assistance with activities of daily living for that person receiving services.

Direct Responsibility- An employee, subcontractor, or volunteer is considered to be in a position that involves direct responsibility for a person receiving services if the employee, subcontractor, or volunteer either has responsibility for the person receiving services or supervisory authority for staff having direct contact with a person receiving services.

More detail on these groups, as well as background check and registry requirements pertaining to them, is included below in the following subsections:

1. Employees, subcontractors, and volunteers who are involved in providing **direct contact** for members

If the employee, subcontractor, or volunteer will be in a position that involves *either* providing direct contact with a member and/or involves direct responsibility for a member, the provider must conduct a criminal background check on that employee, subcontractor, or volunteer which complies with all requirements established in Title 52 for obtaining a criminal background check and/or fingerprint check from the Tennessee Bureau of Investigation or, as an alternative, a criminal background check from a state licensed private investigation company. For an employee, subcontractor, or volunteer 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 employee, subcontractor, or volunteer has lived during the past seven (7) years or since the age of eighteen (18) years, whichever is fewer.

Additionally, the provider must also have a registry check conducted which involves verification that employee, subcontractor, or volunteer's name does not appear on any of the following six registries: (1) The Tennessee Department of Health Elderly or Vulnerable Abuse Registry; (2) The National Sex Offender Registry; (3) Systems for Award Management (SAM); (4) OIG's List of Excluded Individuals/Entities (LEIE); (5) TennCare Terminated Provider List; and (6) The Tennessee Felony Offender Information Lookup (FOIL). A description of each of these six registries are provided below:

(1) The Tennessee Department of Health Elderly or Vulnerable Abuse Registry can be found at https://apps.health.tn.gov/AbuseRegistry/default.aspx. The Department of Health pursuant to TCA § 68-11-100, 1 *et seq.* maintains this registry for individuals substantiated for abuse, neglect, mistreatment, and exploitation of vulnerable persons, which includes persons with intellectual disabilities. The law contains all pertinent provisions for notice to individuals and procedures for an administrative appeal before any registry placement. This check must be performed on the employee, subcontractor, or volunteer prior to having direct contact with persons receiving services and/or direct responsibility as described below.

(2) The National Sex Offender Registry. The National Sex Offender Registry, also known as the Dru Sjodin National Sex Offender Public Website (NSOPW), found at https://www.nsopw.gov/, is a partnership between the U.S. Department of Justice and state, territorial and tribal governments which work together to collect comprehensive information into one national registry led by the Office of Sex Offender Sentencing, Monitoring,

Apprehending, Registering, and Tracking. This check must be performed on the employee, subcontractor, or volunteer prior to having direct contact with persons receiving services and/or direct responsibility as described below.

(3) Systems for Award Management (SAM), found at https://sam.gov/content/home, is an official U.S. Government system that consolidates the capabilities of multiple systems and information sources used by the Federal government in conducting the acquisition and financial assistance process, including grants and cooperative agreements. This check must be performed on the employee, subcontractor, or volunteer prior to having direct contact with persons receiving services and/or direct responsibility as described below and on a monthly basis thereafter.

(4) The OIG's List of Excluded Individuals/Entities (LEIE) can be found at http://exclusions.oig.hhs.gov/ and provides information to the health care industry and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other Federal health care programs.

This check must be performed on the employee, subcontractor, or volunteer prior to having direct contact with persons receiving services and/or direct responsibility as described below and on a monthly basis thereafter.

(5) The TennCare Terminated Provider List (TTPL) can be found at https://www.tn.gov/tenncare/fraud-and-abuse/program-integrity.html. This is a list of providers that TennCare has terminated for cause. If there is a match on the TTPL, a provider should email ProgramIntegrity.TennCare@tn.gov to receive additional verification if necessary. This check must be performed on the employee, subcontractor, or volunteer prior to having direct contact with persons receiving services and/or direct responsibility as described below and on a monthly basis thereafter.

(6) The Tennessee Felony Offender Information Lookup (FOIL) can be found at https://www.tn.gov/correction/redirect-agency-services/foil.html. The information available on this list pertains to Tennessee felony offenders who are or who have been in the custody of the Tennessee Department of Correction or under the Supervision of the Tennessee Board of Probation and Parole. The information is submitted by various jurisdictions within Tennessee. Confirmation and/or elaboration should be obtained from the originating jurisdiction. This check must be performed on the employee, subcontractor, or volunteer prior to having direct contact with persons receiving services and/or direct responsibility as described below.

The criminal background check, including registry checks, must be performed prior to that employee, subcontractor, or volunteer having direct contact with persons receiving services and/or direct responsibility. If a potential employee, subcontractor, or volunteer's name appears on any of the registries listed in (1)- (5) above, that individual is disqualified from providing services.

However, if a potential employee, subcontractor, or volunteer's name does not appear on the registries listed in (1)- (5) above, but the criminal background check returns results of a prior felony or misdemeanor conviction and/or the employee, subcontractor, or volunteer appears on the Tennessee Felony Offender Information Lookup (the 6th registry), the provider must use its discretion as to whether that individual is appropriate to have direct contact with members and/or direct responsibility for that member. This means conducting an individualized assessment of the potential employee, subcontractor, or volunteer's background check. The provider should, therefore, not have a blanket policy of not hiring applicants with prior felony or misdemeanor convictions. The individualized assessment must consider the following three (3) factors:

a. Whether or not the evidence gathered during the individualized assessment shows that the criminal conduct is related to the job in such a way that could place the member at risk;

b. The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person or financial harm to a person; and

c. The time that has passed since the offense or conduct and/or completion of the sentence.

For all employees, subcontractors, and volunteers who qualify to provide services to members, the HCBS provider will maintain proof that requisite criminal background checks, including registry checks, were completed and provide these records to the MCO and/or DDA for review upon request.

For employees, subcontractors, and volunteers of providers who will be providing direct contact with, or direct responsibility for, members, the criminal background check and registry check must have been performed within thirty (30) days of the first day the employee, subcontractor, or volunteer begins providing direct contact with, or direct responsibility for, members.

As it relates to volunteers providing direct contact, providers may accept a criminal background check conducted by an agency which has provided the volunteer instead of conducting an additional background check on the volunteer, as long as the criminal background check meets the provider's criteria (e.g., goes back the same number of years the provider requires for checks of its staff), and was conducted no later than three hundred and sixty-five (365) calendar days earlier from the date the volunteer will begin assisting any member. However, even if the provider is relying on the results of a criminal background check conducted by the volunteer agency, the provider will still conduct the required registry checks of the six registries listed above itself prior to the volunteer providing direct contact with, or direct responsibility for, a member.

2. Employees, subcontractors, and volunteers who will have **incidental** contact only with members

An employee, subcontractor, or volunteer who does not have direct contact with a member or direct responsibility for a member, but who has incidental contact only, is an individual who will ***not*** provide hands on support with any activities of daily living, who does ***not*** have supervisory authority or responsibility for either the member or for staff having direct contact with a member, and who has limited face-to-face interaction with that member. For purposes of this protocol, face-to-face interaction can be conducted both in-person and through virtual interaction with the member.

If the employee, subcontractor, or volunteer will not have direct contact with, or direct responsibility for, a member receiving service, but will instead have incidental contact only, that employee, subcontractor, or volunteer must have registry checks conducted for all six registries listed above prior to having incidental contact with persons receiving services but does not require a criminal background check. If the potential

employee, subcontractor, or volunteer's name appears on any of the registries listed in (1)- (5) above, that individual is disqualified from having incidental contact with members.

However, if the potential employee, subcontractor, or volunteer's name does not appear on the registries listed in (1)- (5) above, but appears on the Tennessee Felony Offender Information Lookup, the provider must use its discretion as to whether that individual is appropriate to have incidental contact with members. This means conducting an individualized assessment. The provider should, therefore, not have a blanket policy of not hiring applicants with prior felony convictions.

For all employees, subcontractors, and volunteers who qualify to provide services constituting only incidental contact with members, the provider will maintain proof that requisite registry checks were completed and provide these records to the MCO, TennCare and/or DDA for review upon request.

3. Employees, subcontractors, and volunteers who will not have direct or incidental contact

If the employee, subcontractor, or volunteer does not meet the definitions above for either providing direct contact or incidental contact to a member, then the background check and registries (as noted above) are not required to be checked for that employee, subcontractor, or volunteer.

Criminal Background Check and Registry Check Oversight and Monitoring for HCBS Providers

The HCBS provider is responsible for complying with all requirements established in both Title 52 and the approved waiver for obtaining a criminal background check and conducting registry checks, as outlined above. Funds may be recouped for services performed by provider employees, subcontractors, or volunteers who have not completed background or registry checks in compliance with this protocol.

MCOs and DDA are required to screen their owners, agents, employees, providers, and subcontractors initially and on an ongoing monthly basis against OIG, SAM, and TTPL.

The MCOs and DDA will continue to follow their distinct processes for review and approval of background check exemptions for potential staff.

It is the responsibility of DDA to provide oversight of compliance with this Protocol for 1915(c), Katie Beckett, CHOICES CLS/CLS-FM, and ECF providers through the Quality Monitoring provisions. The MCOs will provide oversight of compliance for all other CHOICES providers. This will include review of the initial and ongoing background check and registry checks, as applicable, for all new employees, subcontractors,

CONTRACTING, CREDENTIALING AND RECREDENTIALING

Initial Credentialing

Department of Disability and Aging (DDA) is the responsible entity for credentialing per the DDA Credentialing Protocol. Wellpoint will work with TennCare, DDA, and contracted providers to develop and implement a consolidated process for credentialing and re-credentialing long-term services and supports providers, including I/DD MLTSS Programs, that seeks to minimize MCO and provider burden resulting from duplicative review processes when a provider is contracted with more than one MCO.

The consolidated process shall, as applicable, meet the minimum National Committee for Quality Assurance (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/recredentialed 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 (CRA), or in policies or protocols.

Per advisement from DDA, Wellpoint will deem as credentialed and offer a provider agreement to all qualified ICF/IID providers contracted with TennCare and all qualified 1915(c) waiver providers contracted with TennCare and DDA. Wellpoint will abide by the "deemed" status and shall not establish additional requirements or credentialing processes or standards for participation in the Wellpoint network.

As directed by TennCare (which may vary by service type), Wellpoint may contract with any ICF/IID provider or 1915(c) waiver provider credentialed (or re-credentialed) by DDA as meeting qualifications for the delivery of specified services, provided that Wellpoint shall ensure an adequate network to initiate and consistently deliver services in accordance with each member's PCSP or IPP. This shall include Support Coordination services for individuals enrolled in the Statewide or CAC Waivers. (Support Coordination functions for individuals in the Self-Determination Waiver shall be performed by DDA Case Managers.)

Effective February 1, 2023, DDA serves as the credentialing authority for all Katie Beckett (KB) Services- Part A and B (collectively "provider services"), 1915(c), Employment and Community First (ECF) CHOICES, and ECF Providers who also provide CHOICES Waiver Services. Effective June 1, 2024, DDA serves as the credentialing authority for CHOICES Providers who also provide 1915(c), and/ or Katie Beckett services.
Credentialing responsibilities are outlined in DDA's Credentialing Protocol. Wellpoint may contract with any ECF CHOICES provider credentialed by DDA as meeting qualifications for the delivery of specified services, provided that Wellpoint shall ensure an adequate network to initiate and consistently deliver services in accordance with each member's person-centered support plan (PCSP).

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

Wellpoint will, as directed by DDA, 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, Wellpoint 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.

Additionally, Wellpoint will review Preferred Provider Contracting Standards for providers and accept documentation to support any criteria identified as being met (applicable to ECF providers only).

As outlined in the Tennessee Contractor Risk Agreement, at a minimum, credentialing of LTSS providers will include the collection of required documents, to include but not limited to disclosure statements and verification that the provider:

- Has a valid license or certification for the services it will contract to provide as required pursuant to State law or rule, or TennCare policies or protocols;
- Is not 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 processes in place to conduct, in accordance with Federal and State law and rule and TennCare policy, criminal background checks and registry and exclusion checks, which shall include a check of the Tennessee Abuse Registry, National Sexual Offender Registry, TennCare's Terminated Provider List, System for Award Management (SAM), and List of Excluded Individuals/Entities (LEIE), as required in Section A.29.2.2 and to document these in the worker's employment record or otherwise maintain these records on volunteers, as applicable;
- Has completed criminal background checks, including registry and exclusion checks, as applicable,
- Has a policy and process in place for conducting an individualized assessment for workers whose criminal background, registry or exclusion check reveals past criminal conduct.
- Maintains written policies and procedures of their business model, which 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. (fulfilling CRA Requirement A.2.20.3.9)
- Has a process in place to provide and document initial and ongoing education to its employees who will provide services to members that includes, at a minimum (as applicable based on the service(s) the provider will be contracted to deliver):
    - Orientation to the population that the staff will support;
    - Disability awareness and cultural competency training, including person-first language; etiquette when meeting and supporting a person with a disability; and working with individuals who use alternative forms of communication, such as sign language or non-verbal communication, or who may rely on assistive devices for communication or who may need auxiliary aids or services in order to effectively communicate;
    - Ethics and confidentiality training, including HIPAA and HI-TECH;
    - Delivering person-centered services and supports, including;
    - Federal HCBS setting requirements and the importance of the member's experience;
    - Individual-specific training on services specific to each person they will support;
    - Supporting community integration and participation in the delivery of HCBS
    - Facilitating individual choice and control; and
    - Working with family members and/or conservators, while respecting individual choice.
    - An introduction to behavioral health, including behavior support challenges or other cognitive limitations (including Alzheimer's Disease, dementia, etc.) may face; understanding behavior as communication; potential causes of behavior, including physiological or environmental factors; and person-centered supports for individuals with challenging behaviors, including positive behavior supports;
    - The paid caregiver's responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions;
    - Abuse and neglect prevention, identification, and reporting;
    - Reportable event management and reporting;
    - Documentation of service delivery;
    - Use of the EVV System;

    - Any other training requirements specified by TennCare in State Rule or in policies or protocols; and Wellpoint shall submit to TennCare for review and approval a listing of applicable training requirements by service type.
- Has policies and processes in place to ensure:
    - Compliance with Wellpoint's reportable events reporting and management process; and
    - Appropriate use of the EVV system
    - Is compliant with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301© (4)-(5).

At a minimum, recredentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable); compliance with policies and procedures identified during credentialing, including background, registry, and exclusion checks and training requirements, Reportable Event reporting and management, and use of the EVV; and compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

- Wellpoint shall also verify for HCBS providers that any persons required to have background checks, including registry and exclusion checks, as applicable, who have been employed or have begun volunteering since the last credentialing visit have had criminal background checks, including registry and exclusion checks, as applicable, performed pursuant to the requirements in Section A.29.2.2 Except as prescribed by TennCare, for both credentialing and re-credentialing processes, Wellpoint will conduct a site visit, unless the provider is located out of state, in which case Wellpoint may waive the site visit and document the reason in the provider file. As applicable, Wellpoint ensures that providers furnish physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities.
- At a minimum, Wellpoint shall re-verify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid, and/or SCHIP programs.
- Has capacity to provide services in applied geographical servicing area.
- Has policies and processes documented in accordance with NCQA and TennCare CRA requirements.

Re-credentialing of ECF CHOICES and 1915(c) Providers

Effective February 1, 2023, DDA serves as the recredentialing authority for all 1915(c), Employment and Community First (ECF) Waiver program, Katie Beckett (KB) Services- Part A and B (collectively "provider services"), and ECF Providers who provide CHOICES Waiver Services. Effective June 1, 2024, DDA serves as the credentialing authority for CHOICES Providers who also provide 1915(c), and/ or Katie Beckett services. Wellpoint may recredential an ECF CHOICES provider on an ad hoc basis as determined by DDA in collaboration with Wellpoint.

All credentialing requirements and processes can be found in the TennCare/DDA Credentialing and Recredentialing Protocols located https://www.tn.gov/disability-and-aging/provider-information/become-a-credentialed-provider.html#collapse3eaa357aca3445e29dfe39ad6d403cc9-3

Providers will comply with all credentialing, recredentialing and initiatives as instructed by Wellpoint, TennCare and/or DDA. Wellpoint 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 Wellpoint. Provider acknowledges that Wellpoint has the right to monitor Covered Services furnished by Provider to Covered Persons in accordance with Wellpoint 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 Wellpoint must comply as required by TennCare.
Wellpoint 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 a Wellpoint request for information, the request to provide medical records, and credentialing information; at Wellpoint's discretion or a directive by TennCare, Wellpoint shall impose financial consequences against the provider as appropriate.

Self-Direction of Health Care Tasks

Pursuant to Tenn. Code Ann. § 71-5-1414, CHOICES, Employment and Community First (ECF) CHOICES, 1915(c) Waiver, and Katie Beckett Part A members have the option to direct and supervise a paid staff member in the performance of health care tasks that would otherwise be performed by a licensed nurse. This is called Self-Direction of Health Care tasks and is not the same as Consumer Direction or Self-Direction of Home and Community Based Services (HCBS). Self-Direction of Health Care Tasks may be performed in a person's home or during the course of employment or integrated community activities outside the home, as a component of HCBS specified herein.

Providers are not mandated to perform these tasks and may opt out of providing self-directed tasks, and a referral will be presented to providers that opt in.

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 Wellpoint must be accessible to all members.

Providers interact with individuals from diverse cultural backgrounds including, individuals with LEP, individuals with low literacy, individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities. Providers are required to have policies and procedures for delivering services in a nondiscriminatory and culturally competent manner. This includes policies and procedures for: providing free language and communication assistance services to individuals; providing individuals with reasonable accommodations; discrimination complaint procedures; and regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equity and eliminate bias with generating assessment results. Providers' staff members carrying out the terms of the provider agreement must receive annual training on the provider entity's: policies on how to deliver services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. New hires must receive this training within 30 days of joining the organization's workforce.

Providers shall provide any discrimination complaint received relating to TennCare's services and activities within in two (2) days of receipt to TennCare's Office of Civil Rights Compliance (OCRC) at HCFA.Fairtment@tn.gov. Providers agree to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and to assist individuals in obtaining information on how they can report a complaint or get assistance for a disability related need that involves TennCare's services or activities by

contacting OCRC. To satisfy this obligation, providers may direct the individual to OCRC's webpage at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html, to call TennCare Connect at 855-259-0701, or to Wellpoint if the member needs assistance with filing a complaint.

To the extent that providers use electronic and information technology to fulfill contractual obligations with Wellpoint, providers agree to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92 (or any subsequent standard adopted by an oversight administrative body, including the Federal Accessibility Board). To comply with the accessibility requirements for Web content and non-Web electronic documents and software, providers shall use the most current W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher with a goal to transition to WCAG 3 level silver (For the W3C's guidelines see: https://www.w3.org/WAI/standards-guidelines/ and Section 508 standards: https://www.access-board.gov/ict/).

New Provider Training

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

Provider's Roles and Responsibilities

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.

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 (for example, roommate, acquaintance, caregiver). 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.

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: To be considered neglect, an act or omission of an act must have led to serious injury to the member or another person (that is, housemate, community member, staff) 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 (that is, 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 (for example, 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 (that is, 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: To be considered misappropriation, the property must be valued at more than $1000 (class E felony).

REPORTABLE EVENT MANAGEMENT

Reportable Events and Requirements

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 CHOICES, ECF CHOICES, Katie Beckett, 1915(c) waiver, and ICF/IID programs involves a partnership between TennCare, DDA, Managed Care Organizations (MCOs), Fiscal Employer Agents (FEAs) 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.

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 individual's PCSP, including implementation of strategies identified to help mitigate risk, but should not be held responsible if, despite appropriate supports and implementation of appropriate and reasonable risk mitigation strategies, an untoward event occurs. The CHOICES, ECF CHOICES, Katie Beckett, 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.

In HCBS and ICF/IID programs, there are three 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, Wellpoint, FEA, and DDA, as applicable. DDA shall triage all allegations reported via the Abuse Hotline and/or via Reportable Event Form within two business days (unless pending results of medical assessment, laboratory test, expert opinion, or other determination) to determine the need for an investigation. The Event Management Coordinator (EMC) or designee shall provide all requested documentation and information as soon as possible to ensure the disposition is reached within the required 2 business days. Once a disposition is reached by DDA, the responsible provider is notified of the outcome via email by the on-call investigator.

Providers are required to send a copy of the REF to the Independent Support Coordinator (ISC), or DDA Case Manager, as applicable to the person supported, for persons supported by a 1915(c)-state funded waiver.

Although non-reportable events are not reportable to DDA or Wellpoint, 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 DDA and/or the MCO during quality assurance surveys which occur every 12-18 months and/or recredentialing, as applicable.

The expectation is that providers are working with the person and members of the person's team, to include the support coordinator/care coordinator with plans of remediation to prevent all events (reportable or nonreportable) from recurring.

Please email reportable events correspondence to Reportable Events Management at TN-REM@wellpoint.com and submit all reportable events through FormStack at **stateoftennessee-cvlyz.formstack.com/forms/ref**.

Adult Protective Services (APS):
Phone: **888-277-8366**/Fax: **866-294-3961**

Child Protective Services (CPS):
Phone: **877-237-0004**

DDA investigations hotline — 24 hours a day, 7 days a week — for **Tier 1 reportable events only: 888-633-1313 (Statewide)**

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

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. DDA will maintain a statewide system for data collection and analysis for all Tier 1, Tier 2, and Additional Reportable Events and Interventions. Where a Tier 1 or Tier 2 Reportable Event is substantiated at a Class 1 or Class 2 level 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 substantiation. The provider, MCO, and/or DDA, 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. ECF CHOICES, CHOICES, Katie Beckett), 1915(c) waiver, 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 membership and representation are 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.

FRAUD, WASTE, AND ABUSE

First Line of Defense Against Fraud

Wellpoint is 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. This includes any act that constitutes fraud under applicable Federal or State law.

- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.

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. Wellpoint 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 a Wellpoint member identification card. Providers should take measures to ensure the cardholder is the person named on the card. Learn more at **www.fighthealthcarefraud.com.**

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 **833-731-2154**. 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 Wellpoint 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 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 right 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 and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting Wellpoint's www.fighthealthcarefraud.com education site; at the top of the page click "Report it" and complete the "Report Waste, Fraud and Abuse" form

- Calling Wellpoint's Special Investigations Unit fraud hotline at **866-847-8247**.

Any incident of fraud, waste or abuse may be reported anonymously; however, Wellpoint's 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
- Overutilization
- 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, or medical supply company) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist)
- 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
- Relocating to out-of-service plan area and not letting us know
- Using someone else's identification card

When reporting concerns involving a member include:

- The member's name
- The member's date of birth, member ID or case number, if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

Wellpoint's Special Investigations Unit (SIU) reviews all reports of Provider or member fraud, waste and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, Wellpoint may take corrective action with Provider fraud, waste or abuse, which may include, but is not limited to:

- **Written warning and/or education:** Wellpoint sends 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 review**: Wellpoint reviews medical records in context to previously submitted claims and/or to substantiate allegations.

- **Prepayment Review**: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- **Recoveries**: Wellpoint recovers overpayments directly from the Provider. Failure of the Provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU, all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU and is also available in other sections of this manual. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

About Prepayment Review

One method Wellpoint uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to Wellpoint's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, Wellpoint may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to

submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

If, after investigation, the SIU determines a Provider appears to have committed fraud, waste, or abuse the Provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including Provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or Provider to the appropriate regulatory and law enforcement agencies.

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.

Offsets. Wellpoint shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to Provider or Facility against any payments due and payable by the health plan to Provider or Facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the health plan that an Overpayment Amount is due from the Provider or Facility, the Provider or Facility must refund the Overpayment Amount within the timeframe specified in the letter notifying the Provider or Facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, the health plan shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Wellpoint to the Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should the Provider or Facility disagree with any determination, the Provider or Facility shall have the right to appeal such determination under Wellpoint's procedures set forth in this Provider Manual, on condition that such appeal shall not suspend Wellpoint's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Wellpoint reserves the right to employ a third-party collection agency in the event of non-payment.

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 (for example, 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.

PROVIDER AND FACILITY DIGITAL GUIDELINES

Wellpoint understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms.

Wellpoint expects Providers and Facilities will utilize digital tools unless otherwise mandated by law or other legal requirements.

The Digital Guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Wellpoint. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital functionality available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider Enrollment and Network Management
- Demographic updates

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management
- Services through Carelon Behavioral Health

Wellpoint expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes Providers and Facilities using their practice management software and clearinghouse billing vendors.

Providers who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our members transition to digital Member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Wellpoint expects that Providers and Facilities will accept the digital version of the Member identification card in lieu of a physical card when presented. If Providers and

Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and Facilities should leverage these Availity clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response:
    - Wellpoint supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials:
    - The Eligibility and Benefits Inquiry verification application allows Providers and Facilities to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs:
    - Wellpoint has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
    - Wellpoint supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
    - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
    - The Availity Essentials multi-payer Authorization application facilitates prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Wellpoint has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, Claims payment disputes, attachments, and status

<u>Claim submissions status and Claims payment disputes</u>

Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment) and status:

- EDI transaction: X12 837 – professional, institutional, and dental Claim submission (version 5010):
    - Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows Providers and Facilities to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Wellpoint supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – Claims & Payments application
    - The Claims and Payments application enables Providers and Facilities to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
    - The Claim Status application enables Providers and Facilities to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online Claim payment disputes in most markets and for most Claims. It is the expectation of Wellpoint that electronic Claim payment disputes are adopted when and where they are integrated.
- Provider desktop integration via B2B APIs:
    - Wellpoint has also enabled real-time access to Claim status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from Availity.com:

- EDI transaction: X12 275 – patient information, including HL7 payload attachment:
    - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting Claims documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application
    - The Claim Status application enables Providers and Facilities to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
    - Digital Request for Additional Information (Digital RFAI) – the Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic Claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your Claims. Wellpoint supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and Facilities can register, enroll and manage their ERA preference through **Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for Claims, contact Availity Client Services at 800-AVAILITY (282-4548).

To re-enable receiving paper remittances, contact Provider Services.

Electronic Claims payment

Electronic Claims payment is a secure and fast way to receive payment by reducing administrative processes. There are several options to receive Claims payments electronically.

- Electronic Funds Transfer (EFT)

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

  To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient **EnrollSafe User Reference Manual**.

  To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT.
  Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

- Zelis Payment Network (ZPN) electronic payment and remittance combination

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

  Note that Wellpoint may receive revenue for issuing ZPN.

  ERA through Availity is not available for Providers and Facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at 877-828-8770.

Not being enrolled for EFT or ZPN will result in paper checks being mailed.

Section 6: Demographic updates

Provider Data Management (PDM)

Availity Essentials Provider Data Management (PDM) is the digital intake application for Providers and Facilities to submit demographic change requests – it is also where providers can upload a roster with demographic changes. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters and follow the prompts.

For Providers and Facilities using the roster upload option, additional resources are available:

- Error Report:
    - Providers and Facilities can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.
    - Providers and Facilities are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed and the addition, change, or termination will not be updated in our systems
- Results Report: When a roster has the status partially complete or complete a Results Report will be created for any rosters received on and after June 15, 2024. The Results Report is an Excel file that shows the adds and updates made to your provider group's demographic data based on the information contained in a specific roster.
- Use the *Roster Submission Guide:* For Provider and Facilities using the roster upload option, additional information about the Error Report and Results Report can be found in our *Roster Submission Guide*. Find it online at Availity.com > Payer Spaces > Select Payer Tile > Resources > Roster Submission Guide using Provider Data Management.

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