Provider Administration Manual

Managed Long-Term Services and Support
For BlueCare Tennessee providers treating patients with Intellectual & Developmental Disabilities

Effective April 1, 2025

Managed Long-Term Services and Support (MLTSS)

BlueCare Tennessee is proud that you have chosen to become part of Tennessee's greatest network of providers - a network of fine providers that support our wonderful members diagnosed with intellectual developmental disabilities. Because of your commitment to provide quality care, community engagement, and supports to individuals in meeting their goals, you are making a positive impact in the state of Tennessee.

The goals of BlueCare Tennessee are:

- Create a person-centered care management approach to improve the quality-of-care members receive
- Comprehensively manage benefits across the continuum of care, including social and community services
- Integrate services for all physical, behavioral, long-term care, and social need

Our network providers of long-term and community-Based services and supports, coordinators and clinical providers are the heart of each program. Our ability to support our members well is dependent upon the quality of our provider network. You are the cornerstone of our service delivery approach. By joining our network, you help us achieve our goal of providing our members with access to high quality health care services.

Updates and Changes

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most updated version is available online at https://www.bcbst.com/providers/manuals/BCT_PAM.pdf. To request a free, printed copy of this manual, call Provider Services at 1-800-468-9736.

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

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

Thank you,

Your Partners at BlueCare Tennessee

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.

Employment and Community First (ECF) CHOICES Program

(Does Not Apply to CoverKids)

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All 1915c, Employment and Community First (ECF) CHOICES and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

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Employment and Community First CHOICES Program

A. Introduction

The TennCare Employment and Community First (ECF) CHOICES program is a managed care long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program. The primary goal of ECF CHOICES is to promote and support integrated, competitive employment and independent living as the first and preferred option for all individuals with intellectual and developmental disabilities.

ECF CHOICES is designed for people with intellectual and other developmental disabilities who are not currently receiving services. ECF CHOICES offers:

1. Supports for families caring for a person with an intellectual or development disability.
2. Supports to help ECF CHOICES enrollees achieve employment and independent living goals.
3. Residential and other day services to help people who cannot work or who need more support to live in the community achieve their community goals.

B. Eligibility/Enrollment

To be eligible for enrollment in the ECF CHOICES program, an individual must have an intellectual or developmental disability.

Developmental disability in a person over five (5) years of age means a condition that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments,
- Is manifested before twenty-two (22) years of age,
- Is likely to continue indefinitely,
- Results in substantial functional limitations in three (3) or more of the following major life activities:
    - Self-care,
    - Receptive and expressive language,
    - Learning,
    - Mobility,
    - Self-direction,
    - Capacity for independent living; or
    - Economic self-sufficiency; and
- Reflects the person's need for a combination and sequence of special interdisciplinary or generic services, supports, or other assistance that is likely to continue indefinitely and needs to be individually planned and coordinated.

Developmental disability in a person up to five (5) years of age means a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of three (3) substantial functional limitations resulting in developmental disability as defined for persons over five (5) years of age if services and supports are not provided.

If currently enrolled in BlueCare or TennCare*Select* – call the customer service number on the back of the Member ID card.

Intellectual disability is defined as substantial limitations in functioning:

- As shown by significantly sub-average intellectual functioning (IQ 70 or below) that exists concurrently with related limitations in two (2) or more of the following adaptive skill areas:
    - Communication,
    - Self-care,
    - Home living,

- Social skills,
- Community use,
- Self-direction,
- Health and safety,
- Functional academics,
- Leisure; and,
- Work; and,

➢ That is manifested before eighteen (18) years of age.

ECF CHOICES is made up of five (5) Groups, each with distinct eligibility/enrollment requirements and benefits:

Group 4 (Essential Family Supports)

➢ Children under age twenty-one (21) with I/DD living at home with family who meet the Nursing Facility level of care and need and are receiving Home and Community Based Services as an alternative to Nursing Facility Care, or who, in the absence of HCBS, are "At risk of Nursing Facility placement;"
➢ Adults age 21 and older with I/DD living at home with family caregivers who meet the NF level of care 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 in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, 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.

Group 5 (Essential Supports for Employment and Independent Living)

➢ Adults aged twenty-one (21) and older with I/DD who do not meet NF level of care, but who, in the absence of HCBS are "At Risk" of nursing facility placement.
➢ To qualify in this group, the adult must be SSI eligible or qualify in 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.

Group 6 (Comprehensive Supports for Employment and Community Living)

➢ Adults aged twenty-one (21) and older with I/DD who meet NF level of care and need and are receiving specialized services for I/DD.
➢ To qualify in this group, an individual 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.

Group 7 (Intensive Behavioral Family- Centered Treatment, Stabilization, and Supports)

➢ Except as modified in the final approved amendment to the TennCare 1115 Demonstration and only upon approval and implementation of such amendment, children under age twenty one (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 (e.g., State custody, hospitalization, residential treatment, incarceration).
➢ The child must meet the NF level of care and need and receive HCBS as an alternative to NF Care. To qualify in this group, an individual 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. This group shall be implemented by MCO Based on TENNCARE's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements.

Group 8 Intensive Behavioral Community Transition and Stabilization Services

➢ Except as modified in the final approved amendment to the TennCare 1115 Demonstration and only upon approval and implementation of such amendment, adults ages twenty-one (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, an individual 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. This group shall be implemented by MCO Based on TENNCARE's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements.

TennCare enrollees will be enrolled by TENNCARE into ECF CHOICES via the below referral process consisting of three steps: screening, intake, and enrollment.

Screening

Screening provides basic education about the program, including eligibility criteria and enrollment processes, and helps to gather basic information that can be used to determine if the potential applicant is likely to qualify for the program and that allows the potential applicant to be prioritized for intake Based on established prioritization and enrollment criteria. The following outlines the ECF CHOICES screening process:

1. Potential applicants for ECF CHOICES complete an online self-screening tool. For current BlueCare Members who need assistance with completion of the self-screening tool, BlueCare staff will assist the Member via telephone with completion of the self-screening.
2. The results of the applicant self-screenings are captured in a referral tracking system.
3. If the potential applicant does not appear to meet the eligibility criteria for enrollment into ECF CHOICES, the person will be advised accordingly and given the opportunity to be placed on the referral list for potential intake and enrollment into the program at a later time.
4. If the potential applicant does appear to meet the eligibility criteria for enrollment into ECF CHOICES, the process proceeds to the intake phase.

Intake

Intake helps to gather basic information that will help to confirm information provided in the screening process and allows a person to be prioritized for enrollment Based on established prioritization and enrollment criteria. If a potential applicant meets the online screening criteria, the following intake steps occur:

1. BlueCare schedules a face-to-face intake visit with the Member as follows:
    a. For Members who meet screening criteria and are in one of the priority categories for which enrollment is currently open or who may qualify in a reserve slot and for which slots are currently available, the intake visit is to be completed within five (5) business days of the screening.
    b. For all other Members on the referral list, the intake visit is to be completed within thirty (30) calendar days of completing the screening.
2. During the visit, the BlueCare Support Coordinator collects all required supporting documentation to complete the intake packet and gather information that will allow the Member to be prioritized for enrollment by TennCare.
3. If the documentation obtained is sufficient to reasonably establish that the Member has an ID or DD:

a. BlueCare may proceed with the enrollment steps if the Member qualifies for an available reserve slot Based on an aging caregiver.
b. BlueCare may proceed with the enrollment steps if the Member qualifies in an available program slot Based on prioritization criteria for which enrollment is currently open.
c. BlueCare may submit a referral to the interagency review committee if the Member could potentially qualify for a reserve slot Based on emergent circumstances or multiple complex health conditions.
d. BlueCare may confirm or modify as applicable the person's placement on the ECF CHOICES referral list.

4. If the documentation obtained is not sufficient to reasonably establish that the person has an ID or DD, BlueCare will advise the Member that they do not appear to meet target population for enrollment into ECF CHOICES. BlueCare will further advise that the Member may request to remain on the ECF CHOICES referral list.

Enrollment

Enrollment into ECF for existing BlueCare Members occurs when a person has been determined to meet criteria for an available reserve slot or for one of the prioritization categories for which enrollment is currently open, and when there is an appropriate slot available for the person to enroll. Enrollment includes:

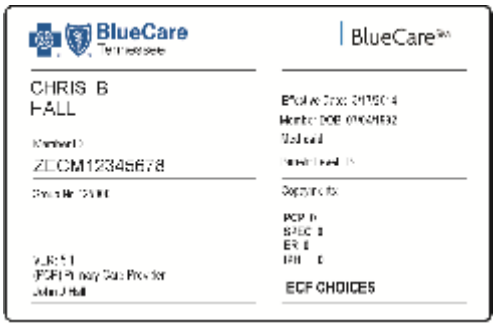
1. Within 5 business days of determination to proceed with enrollment of a Member into ECF CHOICES, the Support Coordinator conducts a second face-to-face visit to complete the enrollment packet. As indicated above, the intake and enrollment visit may be combined in circumstances where it is known at intake that the Member may be enrolled.
2. During the enrollment visit, the Support Coordinator provides to the Member:
    a. ECF CHOICES Education materials
    b. Freedom of ECF CHOICES Counseling
3. The Support Coordinator completes an enrollment packet which includes:
    a. All documentation necessary for a Level of Care Determination (Pre-Admission Evaluation)
    b. Any additional evidence, including documented observations, supporting ID and/or DD diagnosis.
    c. Signed acknowledgement by Member that general information about ECF CHOICES and information about estate recovery and patient liability counseling was provided.
    d. All other documents as applicable such as: Freedom of ECF CHOICES Form, Consumer Direction Participation Forms, Initial Person-Centered Support Plan, etc.
4. Within 5 business days of the face-to-face enrollment visit, BlueCare submits all necessary documentation to TennCare.

TennCare reviews the information submitted by BlueCare to confirm the Member is in the target population and determines medical eligibility. The enrollment into ECF CHOICES it not final until the Member information is transmitted from TennCare to BlueCare Tennessee via the electronic 834 enrollment file. Notification via the 834 occurs after TennCare approves financial eligibility and Nursing Facility as applicable.

Upon enrollment, each ECF CHOICES Member receives a plastic Member ID card reflecting his/her Primary Care Provider (PCP) name and effective date. A new ID card is issued each time the Member changes his or her PCP. The single contact number for BlueCare Tennessee ECF CHOICES is located on the back of the ID card.

A sample copy of the BlueCare ECF CHOICES Member ID card follows:

Front



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C. Benefits

1. Covered Services

ECF CHOICES Members receive the same benefits as all other BlueCare Members (see Section IV. Benefits, in this Manual). Additionally, the following long-term services and supports are available to ECF CHOICES Members when the services have been identified as needed by the BlueCare Tennessee Support Coordinators or person-centered support plan (PCSP), as applicable.

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 aged 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
Assistive Technology/Enabling technology (up to $5,000 per calendar year for a combination of the two services)	X	X	X	X	X
Minor home modifications (up to $6,000 per project; $10,000 per	X	X	X	X	X

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
calendar year; and $20,000 per lifetime)					
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
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 support 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[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

[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 ages 21 and older

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
➢ 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 • Co-worker supports • Career advancement 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

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

2. Exclusions

BlueCare Tennessee makes the exclusion list available through this Manual (see Section IV. Benefits). **Note: *The Division of TennCare is solely responsible for the addition or deletion of any service or supply.***

The Division of TennCare's benefit exclusions can also be viewed in the **Exclusions** section of the TennCare Rules located at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-20.20190822.pdf (TennCare Medicaid) or https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-14.20190403.pdf (TennCare Standard). The services, products and supplies listed in the exclusion rules apply to all Members unless the rules require a Medical Necessity review for Members under the age of 21 years. Providers are encouraged to routinely view the most current Exclusions list available on the Division of TennCare's website. (See above TennCare Rules Web address.)

3. Consumer Direction

Each ECF CHOICES Member assessed to need specified types of HCBS including personal assistance, supportive home care, respite, and community transportation; and/or any other service specified in TennCare rules and regulations as available for consumer direction is given the opportunity to elect to direct and manage (or to have a representative 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).

A *Consumer-Directed Worker* is an individual who has been hired by an ECF CHOICES Member participating in consumer direction of eligible ECF CHOICES HCBS or his/her representative to provide one or more eligible ECF CHOICES HCBS to the Member. Worker does not include an employee of an agency that is being paid by a MCO to provide HCBS to the Member.

4. Self-Direction of Health Care Tasks

The MCO shall, in accordance with state law, and TennCare rules and regulations, permit CHOICES, ECF CHOICES, and 1915(c) waiver members the option to direct and supervise a paid personal aide worker who is providing eligible CHOICES, ECF CHOICES HCBS, or 1915(c) waiver HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse.

Self-direction of health care tasks for ECF CHOICES is a decision by an ECF CHOICES member to direct and supervise a person paid to deliver ECF HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that an ECF CHOICES member may elect to have performed as part of the delivery of eligible ECF HCBS the member is authorized to receive.

The individual or caregiver who chooses to self-direct a health care task is responsible for initiating self-direction by informing the health care professional who has ordered the treatment that involves the health care task of the individual or caregiver's intent to perform that task through self-direction. When a licensed health care provider orders treatment involving a health care task to be performed through self-directed care, the responsibility to ascertain that the patient or caregiver understands the service and will be able to follow through on the self-directed care task is the same as it would be for a member or caregiver who performs the health care task for the member or caregiver’s own self, and the licensed health care provider incurs no additional liability when ordering a health care task that is to be performed through self-directed care. The role of the caregiver or Direct Support Professional (DSP) in self-directed care is limited to the physical aspect of health.

An ECF CHOICES member shall not receive additional amounts of any service because of his/her decision to self-direct health care tasks. Rather, the health care tasks shall be performed by the worker while delivering eligible ECF CHOICES services already determined to be needed, as specified in the PCSP.

Ongoing monitoring of the worker performing self-directed health care tasks is the responsibility of the member or his/her Representative. Members are encouraged to use a home medication log as a tool to document medication administration. Medications should be kept in original containers, with labels intact and legible.

D. Support Coordination

1. Person-Centered Support Plan (PCSP)

The Person-Centered Support Plan is a written plan developed by the Support Coordinator using a person-centered support planning process that 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 to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services.

The planning process is directed by the Member with long-term support needs unless he or she has a court-appointed guardian or conservator and may include a representative whom the Member has freely

chosen to assist the Member with decision-making, and others chosen by the Member to contribute to the process. This planning process, and the resulting initial support plan, will assist the Member in achieving a personally defined lifestyle and outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth.

The Person-Centered Support Plan will include, but not be limited to:

- Pertinent demographic regarding the Member, including but not limited to, the Member's current address and phone number(s), the name and contact information of any representative, and a list of other persons authorized by the Member to have access to health care related information.
- Documentation that the setting in which the Member resides is chosen by the Member and meets the HCBS Settings Rule Requirements.
- The Member's strengths and interests.
- Person-centered goals and objectives, including employment (as applicable) and integrated community living goals, and desired wellness, health, functional, and quality of life outcomes for the Member, and how ECF CHOICES services are intended to help the Member achieve these goals.
- Risk factors for the Member and measures in place to minimize them.
- Support, including specific tasks and functions that will be performed by family members and other caregivers.
- Caregiver training or supports identified through the caregiver assessment that are needed to support and sustain the caregiver's ability to provide care for the Member.
- Home health and private duty nursing that will be authorized by BlueCare Tennessee, as well as home health, private duty nursing, and long-term care services the Member will receive from other payor sources.
- ECF CHOICES HCBS that will be authorized by BlueCare Tennessee, including:
    - The amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided.
    - How such services should be delivered, including the Member preferences; and
    - The schedule at which such care is needed.
- A detailed back-up plan for situations when regularly scheduled ECF HCBS Providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and will include the names and telephone numbers of persons and agencies to contact, and the services provided by listed contacts; and
- Description of the Member's current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the Member's physical, behavioral and functional needs.
- Description of the Member's physical environment and any modifications necessary to ensure the Member's health and safety.
- Description of medical equipment used or needed by the Member (if applicable).
- Description of any special communication needs including interpreters or special devices.
- The primary language spoken by the Member and/or his or her primary caregiver, or the use of other means of effective communication, such as, sign language and other auxiliary aids or services, as applicable, and a description of any special communication needs including interpreters or special devices.
- A description of the Member's psychosocial needs, including any housing or financial assistance needs which could impact the Member's ability to maintain a safe and healthy living environment.
- For Members receiving CBRA services, a description of the Member's capabilities and desires regarding personal funds management.
- Description of any other services that will be provided to the Member.
- Relevant information regarding the Member's physical health conditions.
- Frequency of planned support coordinator contacts as needed.
- For Members participating in consumer direction, additional information should be included to identify the specific services that will be consumer directed and if the Member requires a representative to participate in consumer direction.

- Any steps the Member should take in the event of an emergency that differ from standard emergency protocol as well as a disaster preparedness plan specific to the Member; and
- The Member's TennCare eligibility end date.

2. New Member Support Coordination

The Support Coordinator will contact the ECF CHOICES Member within ten (10) business days of notice of the Member's enrollment in ECF CHOICES, conduct a face-to-face visit with the Member, initiate a comprehensive needs assessment in a manner sufficient to ensure needs are identified and addressed in the PCSP, as applicable, conduct a caregiver assessment, and authorize and initiate ECF CHOICES HCBS.

The PCSP will identify ECF CHOICES HCBS that are needed by the Member on an interim basis while the comprehensive PCSP is developed. ECF CHOICES HCBS identified in the PCSP shall be authorized for no more than thirty (30) calendar days, pending development of the PCSP which shall identify ongoing ECF CHOICES HCBS needed.

Within thirty (30) calendar days of the enrollment notice, the support coordinator will complete the comprehensive needs assessment, develop the PCSP and authorize and initiate services as specified in the initial PCSP.

3. Ongoing Support Coordination

ECF CHOICES Group 4 Members will be contacted by their support coordinator at least quarterly. Such contacts shall be either in person or by telephone. These Members shall be visited in their residence face-to-face by their support coordinator at least semi-annually. 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.

ECF CHOICES Group 5 Members will be contacted by their support coordinator at least monthly. The contacts will be either in person or by telephone. These Members will be visited in their residence face-to-face by their support coordinator at least quarterly. Face-to-face and/or telephone contacts will be conducted more frequently when appropriate Based on the Member's needs and/or request which will be documented in the PCSP or Based on a significant change in needs or circumstances.

ECF CHOICES Group 6 Members determined by an objective assessment to have low to moderate need and not to have exceptional medical or behavioral needs will be contacted by their support coordinator at least monthly either in person or by telephone. These Members will be visited in their residence face-to-face by their support coordinator at least bi-monthly (i.e., every other month). Face-to-face and/or telephone contacts will be conducted more frequently when appropriate Based on the Member's needs and/or request which will be documented in the PCSP or Based on a significant change in needs or circumstances.

ECF CHOICES Group 6 Members determined by an objective assessment to have high need and Members in ECF CHOICES Group 6 determined by an objective assessment to have exceptional medical or behavioral needs (including Members with low to moderate need who have exceptional medical or behavioral needs) will be visited in their residence face-to-face by their support coordinator at least once a month. More frequent face-to-face and/or telephone contacts will be conducted when appropriate Based on the Member's needs and/or request which will be documented in the PCSP or Based on a significant change in needs or circumstances.

ECF CHOICES Group 7 Members will 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, during the first month of enrollment into Group 7, the thirty (30) days leading up to any planned transition out of Group 7, and the thirty (30) days following transition out of Group 7 into another ECF CHOICES Group. A minimum of at least one weekly contact will continue until Intensive Behavioral Family Centered Treatment, Stabilization, and Supports (IBFCTSS) services are in place and for at least the first two weeks following the initiation of IBFCTSS services. Members will be visited face-to-face in their residence, by the ISCT at least monthly, thereafter. Face-to-face and/or telephone or other non-in-person contacts as requested by the Member will be conducted more frequently when appropriate Based on the Member's needs and/or request and will 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) will be present for all minimum face-to-face contacts.

ECF CHOICES Group 8 Members will 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 during the first month of enrollment into Group 8, during the thirty (30) days leading up to any planned transition out of Group 8, and the thirty (30) days following transition out of Group 8 into another ECF CHOICES Group. A minimum of at least one weekly contact will continue until Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) are in place and for at least the first two weeks following initiation of IBCTSS. Members will be visited face-to-face in their residence by their ISCT at least monthly thereafter. Face-to-face and/or telephone or other non-in-person contacts as requested by the Member will be conducted more frequently when appropriate Based on the member's needs and/or request and will 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) will be present for all minimum face-to-face contacts.

The Member's Support Coordinator/support coordination team will ensure that the Member reviews, signs and dates the PCSP as well as any updates, as necessary. The Support Coordinator will also sign and date the initial PCSP, along with any updates, as specified by TennCare. The Provider, also, receives copies of the approved PCSP; their acknowledgment by electronic mechanism or through proxy is obtained, indicating their receipt and understanding of all relevant service provisions they will be providing to the Member.

When the refusal to sign is due to a Member's request for additional services, (including requests for a different type or an increased amount, frequency, scope, and/or duration of services than what is included in the PCSP) BlueCare Tennessee 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, BlueCare Tennessee will ensure continuation of at least the level of services in place at the time the annual or revised PCSP was developed until a resolution is reached, which may include resolution of a timely filed appeal. BlueCare Tennessee will not use the Member's acceptance of services as a waiver of the Member's right to dispute the PCSP, as applicable or as cause to stop the resolution process.

The Member's Support Coordinator/support coordination team will provide a copy of the Member's completed PCSP, including any updates, to the Member, the Member's representative, and the Member's community residential alternative Provider, as applicable. The Member's Support Coordinator/support coordination team will provide copies of the Provider PCSP, as applicable to other Providers authorized to deliver care, and will ensure that Providers are informed in writing of all relevant information needed to ensure the provision of quality care for the Member and to help ensure the Member's health, safety and welfare, including the tasks and functions to be performed.

Within five (5) business days of completing a reassessment of a member's needs, the Member's Support Coordinator will update the Member's initial PCSP as appropriate, authorize and initiate HCBS in the updated PCSP, as applicable.

The Member's Support Coordinator will inform each Member of his or her eligibility end date and educate Members regarding the importance of maintaining TennCare ECF CHOICES eligibility, that eligibility must be re-determined at least once a year, and that Members receiving ECF CHOICES HCBS will be contacted by TennCare near the date a re-determination is needed to assist them with the process, e.g., collecting appropriate documentation and completing the necessary forms.

4. Integrated Support Coordination Team

Integrated Support Coordination Team (ISCT) – For purposes of ECF CHOICES Groups 7 and 8, the team consisting of the Member's Support Coordinator and the Behavior Supports Director as defined in 2.29.1.3.7 or a similarly qualified behavior supports professional shall be responsible for performing in close collaboration the required Support Coordination functions as specified in this Contract, including (but not limited to) comprehensive initial and ongoing assessments, development and implementation of the PCSP, monitoring progress and outcomes, and transition planning.

5. Authorizations

BlueCare Tennessee does not require home and community-based services to be ordered by a treating Physician, but the Support Coordinator may consult with the treating Physician as appropriate regarding the Member's physical health, behavioral health, and long-term service and support needs and in order to facilitate communication and coordination regarding the Member's physical health, behavioral health, and long-term services and supports.

For Members enrolled in ECF CHOICES the Support Coordination team will be responsible for ensuring services are authorized and initiated as outlined in the Member's initial PCSP within ten (10) business days of notice of Member's enrollment with the exception of the following:

ECF CHOICES HCBS identified in the PCSP, as applicable shall be authorized for no more than thirty (30) calendar days, pending development of the PCSP which shall identify ongoing ECF CHOICES HCBS needed. Within thirty (30) calendar days of the enrollment notice, the support coordinator will complete the comprehensive needs assessment, develop the PCSP and authorize and initiate services as specified in the PCSP.

1. Assistive Technology – thirty (30) days
2. Minor Home Modifications – ninety (90) days
3. Respite – In accordance with the Member's needs as specified in the PCSP

Services must be provided in accordance with the approved PCSP, within the Member's service schedule, and be authorized, as applicable, in order to receive reimbursement for the services rendered. The service authorization will include the amount, frequency and duration of each service to be provided and the schedule at which such care is needed, as applicable, the requested start date, and other relevant information as needed.

6. Coordination with State and Local Departments and Agencies

Support Coordinators collaborate with other state and local departments and agencies to verify that coordinated care is provided to Members. This includes, but is not limited to coordination with:

- Tennessee Department of Disability and Aging (DDA) for purposes of the integration and coordination of care.
- Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with Member groups and health service Providers.
- Tennessee Department of Human Services (DHS) and Department of Children's Services (DCS) Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect.
- Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to determine that school-Based services for students with special needs are provided.
- Tennessee Department of Disability and Aging (DDA) and Division of TennCare, Long Term Services and Supports Division for the purposes of coordinating care for Members requiring long-term services and supports.
- Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service Provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

E. Provider Roles and Responsibilities

1. Primary Care Provider

Primary Care Providers (PCPs) are responsible for the overall health care of ECF CHOICES Members assigned to them. Responsibilities associated with the role include, but are not limited to:

- Coordinating the provision of initial and primary care.
- Providing or making arrangements for all Medically Necessary and Covered Services.
- Initiating and/or authorizing referrals for specialty care.
- Monitoring the continuity of Member care services.
- Routine office visits for new and established Members.

- ECF CHOICES Members services.
- Collaboration with the care coordinator.
- Hearing services including: screening test, pure tone audiology, air only audiology, pure tone audiometry and air only audiometry hearing services;
- Counseling and risk intervention, family planning;
- Immunizations;
- Administering and interpreting of health risk assessment instrument;
- Medically Necessary X-ray and laboratory services;
- In-office test/procedures as part of the office visit;
- Maintaining all credentials necessary to provide Covered Member Services including but not limited to admitting privileges, certifications, 24-hour call coverage, possession of required licenses and liability insurance ($1,000,000 individual and $3,000,000 aggregate), and compliance with records and audit requirements; and
- Adhering to the Access and Availability Standards (outlined in Section VII. Member Policy in this Manual).

2. Support Coordinator

The Support Coordinator is the individual who has primary responsibility for performance of support coordination activities for ECF CHOICES Members. For ECF CHOICES Members, the Member's Support Coordinator shall ensure continuity and coordination of physical health, behavioral health, and long-term services and supports, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term service and support Providers.

The Support Coordinator will:

1. Conduct the comprehensive assessment to develop the Person-Centered Support Plan (PCSP) for all ECF CHOICES Groups Based on the Member's needs;
2. Provide information to the Member about preferred Providers and service Providers to enable Members to make an informed decision about their choice and selection of Providers; will also assist the Member in identifying Providers that are linguistically competent in the Member's primary spoken language or sign language, or other forms of communication including assistive devices;
3. Support the ECF CHOICES Member in identifying and meeting goals for integrated employment and community integration;
4. Assist Members with identifying natural supports to help meet the Member's life goals;
5. Will meet face-to-face with Members in accordance to the minimum contact schedule as outlined by TennCare;
6. Review the PCSP, as applicable to ensure that ECF CHOICES services furnished are consistent with the nature and severity of the Member's disability and to determine the appropriateness and adequacy of care and achievement of outcomes and objectives outlined in the PCSP, as applicable;
7. Develop an emergency and disaster plan with the Member and appropriate caregivers. The Safety Plan will be included in the PCSP and must include, at a minimum, detailed and (reading level) appropriate instructions on who to contact in case of an emergency;
8. Review with the Member and appropriate caregivers on a regular basis the plan and ensure that all contact information is current;
9. Be available by telephone through an answered office telephone during normal business hours (to be specified to Member);
10. Be available by cell telephone/pager outside of normal business hours* (to be specified to Member);
11. Install appropriate voice message advice on its main office telephone system providing simple instructions for contacting appropriate authorities in emergency situations.

*If the Support Coordination Department does not use a cell telephone/pager system outside of normal business hours, a contract must be implemented with an established emergency response center for after-hours telephone answering.

3. ECF CHOICES Long-Term Services and Supports Providers

Providers are responsible for providing ECF CHOICES HCBS to meet the needs of ECF CHOICES Members in a timely manner according to the Person-Centered Support Plan (PCSP). The ECF Provider shall provide covered services to ECF CHOICES Members in accordance with the provisions outlined in their executed Provider Contract. Responsibilities associated with these services include, but are not limited to:

1. Participation in the person-centered support planning process driven by the ECF CHOICES Member;
2. Collaboration with the Support Coordinator to help ensure the PCSP is implemented timely and convenient for the ECF CHOICES Member;
3. Support member with Person-Centered SMART goals as documented in the PCSP for ECF CHOICES members.
4. Upon acceptance of an ECF CHOICES Member to provide approved services, ensure that sufficient staffing is in place to the support the amount, frequency, duration, and scope of each ECF service;
5. Initiation of ECF CHOICES HCBS within the time frame prescribed in the authorized PCSP;
6. Signing the Member's PCSP indicating understanding and agreement to Provider and deliver care to ECF CHOICES Members without deviation unless approved by the Contractor;
7. Continuity of Provider services to the ECF CHOICES Member when a Provider change is initiated, in accordance to the PCSP until the ECF CHOICES Member has been transitioned to a new Provider;
8. Use of EVV system for applicable services (process to monitor ECF CHOICES HCBS using electronic visit verification (EVV) for the TennCare ECF CHOICES program);
9. Notifying a Member's Support Coordinator, as expeditiously as warranted by the Member's circumstances, of any significant changes in the Member's condition or care, hospitalizations, or recommendations for additional services;
10. Monitoring and immediately addressing service gaps, including back-up staff;
11. Conducting background checks on its employees, subcontractors, and agents, prior to providing services, in accordance with state law and TennCare policy;
12. Ensure staff is adequately trained in accordance to all mandatory training, and providing attestations to such training upon request and during Provider site visits
13. Report suspected abuse, neglect, and exploitation of ECF CHOICES Adult Members in accordance with TCA 71-6-103 and report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605;
14. Comply with Department of Disability and Aging (DDA) investigations as prescribed by TennCare protocol;
15. Investigating and reporting reportable events;
16. Compliance with the HCBS Settings Rule detailed in 42 C.F.R 441.301 C (4) – (5);
17. Providing current financial solvency when providing Community Living Supports services; and
18. Reporting ECF CHOICES events to the Non-Discrimination Compliance Coordinator as applicable.

F. Employment and Community First (ECF) CHOICES Staff Training

Direct Support Professional (DSP)

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 TNDDA 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://www.tn.gov/didd/divisions/training.html.
The aligned training requirements were rolled out February 1, 2023, with a 90-day grace period. Agencies will need to implement the new DSP requirements between February 1st and April 30th. A provider is

expected to establish a date for when they will transition to the new aligned training, making this date of transition available upon request to DDA Quality Assurance or other DDA entities as requested. Since QA conducts a retrospective review, QA will refer to the current training requirements for review of employees hired before the provider's transition to the aligned training. Employees hired on or after the provider's established date of transition to the aligned training will be assessed by QA based upon these new aligned training requirements.

- See all training and DSP training requirements and timelines here at this link: Training (tn.gov)
- https://www.dropbox.com/s/lujlsysguz5fqz1/DSP%20Training%20Requirements%201915c%20and%20ECF.pdf?dl=0

Job Shadowing

Note: For ECF DSPs Providing Services **other than** Employment Services. If an ECF DSP is only providing employment services, the ECF DSP only has to complete the shadowing required for employment services.

Job shadowing for the Employment and Community First CHOICES (ECF) Direct Support Professional (DSP) shall include a combination of hours that address the ECF DSP's experience level with people who have intellectual/developmental disabilities (IDD), with ECF services the DSP will be providing, and with the particular Member(s) the ECF DSP will be supporting. Job shadowing hours shall follow the following guidelines:

Types of Job Shadowing

- Realistic Job Preview: Within first week of hire, ECF DSPs new to working with people with IDD should shadow to obtain a realistic job preview**:** 2-4 hours; minimum 2 hours.
- Type of Service: The ECF DSP new to providing ECF services should shadow in each type of service(s) they will provide: 4-8 hours per service type; minimum 4 hours per service type.
- Specific to the Member: The ECF DSP should job shadow Based on the Member(s) that they will begin supporting: 2-4 hours; minimum 2 hours.

DSP Categories (Based on experience)

- New DSP (no experience with people with IDD or ECF): Needs to complete all three (3) types of job shadowing listed above.
- New to ECF service: Has experience with people with IDD but no ECF experience - Needs to complete #2 & #3 types of job shadowing listed above.
- DSP experience as ECF Provider: Has experience working with people with IDD in ECF services, but no experience specific to the Member(s) to be supported - Needs to complete #3 type of job shadowing listed above.

Job Shadowing Expectations

- Ideally, to reduce the amount of job shadowing an ECF DSP needs to complete, the shadowing should be with an experienced ECF DSP (or ECF DSP supervisor who is trained as an ECF DSP) serving the specific member(s) to be supported in the type of ECF service(s) that the new ECF DSP will be providing to that Member. For example, if a new ECF DSP shadows for four hours in the service type they will be providing and with the Member(s) they will be supporting, this time can count in meeting the above requirements for both shadowing for Type of Service and shadowing Specific to the Member.
- If the Member(s) to be supported is newly enrolled or new to the Provider, the shadowing shall be with an experienced ECF DSP (or ECF DSP supervisor who is trained as an ECF DSP) serving an ECF Member with similar support needs in the type of ECF service(s) that the new ECF DSP will be providing.
- If an ECF Member with similar support needs is not being served by the Provider, the shadowing will be with an experienced ECF DSP (or ECF DSP supervisor who is trained as an ECF DSP) in the type of ECF service(s) that the new ECF DSP will be providing.
- Job shadowing should include shadowing of the delivery of all types of ECF services (non-employment) that the ECF DSP will be assigned to provide.

- If the agency is beginning provision of a new ECF service and does not have an experienced ECF DSP, the agency is expected to use an ECF DSP supervisor who is trained on the ECF service(s) to accompany the ECF DSP to begin the ECF service(s) with the Member, thereby allowing the new ECF DSP to shadow the ECF DSP supervisor who will model quality service provision and support.

G. Staff Training for Employment Providers

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
    - Job coaching for individualized, integrated employment
    - Job coaching for individualized, integrated self-employment
- Co-worker supports
- Career advancement
- Supported Employment – Small Group Support
- Integrated Employment Path Services

There are core qualifications that all staff providing ECF CHOICES Employment Services must meet.

These are addressed in first section below. There are additional requirements for training and/or certification depending on whether the staff are serving in the capacity of Job Coach, Job Developer, Certified Benefits Counselor or Supported Employment Supervisor/Manager. These requirements have been specifically defined to best position ECF CHOICES Employment Services providers to support individuals with ID/DD enrolled in the program in achieving their employment goals.

Core Requirements

There are basic core qualifications for all staff providing ECF CHOICES employment services. Any staff providing any Employment Service under ECF CHOICES 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 service recipient is not fluent in English
- Able to read and understand instructions, perform record-keeping and write reports
- Has a General Equivalency Degree (GED) or high school diploma
- Pass a criminal background check, and not listed on the Tennessee Department of Health Abuse Registry (TNDOH) and National Sexual Offender Registry
- If driving is involved in job duties, has valid driver's license and automobile liability insurance. If using own vehicle to transport ECF or 1915(c) members is involved in job duties, appropriate insurance coverage for this purpose. Provider agency may contribute toward cost of appropriate insurance coverage to transport ECF members.
- Completion of required training for all DSPs- found in TennCare training protocol
- 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 work included teaching in an employment setting (preferred but not required)

The following link on the DDA website provides all current training requirements and minimum staff qualifications for Employment and Community First CHOICES employment services, and the associated trainings and/or certificates required, including the supported employment manager/supervisor.

https://www.dropbox.com/scl/fi/difqgvsnoxvt0vxhny0g4/Employment-Staff-Training-Requirements-for-All-HCBS-Programs.pdf?rlkey=6aqgs56jryq1zbklqqpxd78d2&dl=0

H. ECF CHOICES Provider Agreement Requirements

Each Provider agency must sign the BlueCare Tennessee Employment and Community First CHOICES Provider Agreement, and a properly executed copy must be on file with the BlueCare Tennessee Provider Relations Division. All provider agreements contracts or templates and revisions thereto must be approved in writing in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof. Provider agreements shall not contain covenant-not-to-compete requirements or terms requiring a provider to not provide services for any other TennCare MCO. Furthermore, BlueCare Tennessee shall not execute any provider agreements that contain compensation terms that discourage providers from serving any specific eligibility category or population covered by the CRA.

Definitions:

BCT Provider Administration Manual or Provider Manual - The manual contained on the BCT website at http://bluecare.bcbst.com, the terms and conditions of which are incorporated by reference herein and made a part hereof, and which contain information, including, but not limited to, operating policies and procedures as established by BCT for health care and non-health care Providers Based upon individual Participation Criteria.

ECF CHOICES Groups (Group) - One of the five groups of TennCare enrollees who are enrolled in ECF CHOICES. All groups in ECF CHOICES receive services in the community. These Groups are:

Group 4 (Essential Family Supports) - Children under age twenty one (21) with I/DD living at home with family who meet the NF level of care 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 adults age 21 and older with I/DD living at home with family caregivers who meet the NF level of care 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 in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, 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.

Group 5 (Essential Supports for Employment and Independent Living) - Adults age twenty-one (21) and older I/DD who do not meet nursing facility level of care, but who, in the absence of HCBS are "At Risk" of nursing facility placement. To qualify in this group, the adult must be SSI eligible or qualify in 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.

Group 6 (Comprehensive Supports for Employment and Community Living) - Adults age twenty-one (21) and older with I/DD who meet nursing facility level of care and need and are receiving specialized services for I/DD. To qualify in this group, an individual 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.

Group 7 (Intensive Behavioral Family Centered Treatment, Stabilization and Supports (IBFCTSS) (children under age twenty one (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 (e.g., State custody, hospitalization, residential treatment, incarceration).

Group 8 Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) is targeted primarily to providing short-term intensive 24/7 community-Based behavioral-focused transition and stabilization services and supports to assist adults aged 18 years and older with intellectual and/or developmental disabilities (I/DD) and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities.

ECF CHOICES Member or Member - A TennCare enrollee who: (i) has been enrolled by TennCare into ECF CHOICES; and (ii) is enrolled with BCT under the provision of the CRA.

Clean Claim - A claim received by BCT for adjudication that requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by BCT.

Community-Based Residential Alternatives to Institutional Care (CBRA)- For purposes of CHOICES and ECF CHOICES:

1. Residential services that offer a cost-effective, community-Based alternative to nursing facility care for individuals who are elderly and/or adults with physical disabilities and for individuals with I/DD.
2. CBRAs include, but are not limited to:
    a. services provided in a licensed facility such as assisted care living facilities and critical adult care homes, and residential services provided in a licensed home or in the person's home by an appropriately licensed Provider such as Community Living Supports and Community Living Supports-Family Model; and
    b. Companion care.

Community Living Supports (CLS) - A community-Based residential alternative service for seniors and adults with disabilities that encompasses a continuum of support options for up to four individuals living in a home that supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under section 1915(c) of the Act, including those requirements applicable to Provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need or initial SP, as applicable.

Community Living Supports – Family Model (CLS-FM) - A Community-Based residential alternative service for seniors and adults with disabilities that encompasses a continuum of support options for up to three individuals living in the home of trained family caregivers (other than the individual's own family) in an adult foster care arrangement. In this type of shared living arrangement, the Provider allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and a family, and provide the individualized services that support each resident's independence and full integration into the community, ensure each resident's choice and rights, and support each resident in a manner that comports fully with standards applicable to HCBS settings delivered under section 1915(c) of the Act, including those requirements applicable to Provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need or initial SP, as applicable.

Community Living Supports (CLS) Ombudsman - The CLS Ombudsman will help to ensure Member choice in the selection of their CLS or CLSFM benefit, provider, setting, and housemates; (II) Provide Member education, including rights and responsibilities of Members receiving CLS or CLS-FM, how to handle quality and other concerns, identifying and reporting abuse and neglect, and the role of the CLS Ombudsman and how to contact the CLS Ombudsman; (III) Provide Member advocacy for individuals receiving CLS or CLS-FM services, including assisting individuals in understanding and exercising personal rights, assisting Members in the resolution of problems and complaints regarding CLS or CLS-FM services, and referral to Adult Protective Services (APS) of potential instances of abuse, neglect or financial exploitation; and (IV) Provide systems level advocacy, including recommendations regarding potential program changes or improvements regarding the CLS or CLS-FM benefit, and immediate notification to TennCare of significant quality concerns.

Consumer-Directed Worker (Worker) – An individual who has been hired by a CHOICES or ECF CHOICES Member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or his/her representative to provide one or more eligible CHOICES or ECF CHOICES HCBS to the Member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the Member.

Consumer Direction of Eligible CHOICES or ECF CHOICES HCBS – The opportunity for a CHOICES or ECF CHOICES Member assessed to need specified types of CHOICES or ECF CHOICES HCBS including for purposes of CHOICES, attendant care, personal care, in-home respite, companion care; and for purposes of ECF CHOICES, personal assistance, supportive home care, hourly respite, and community transportation; and/or any other service specified in TennCare rules as available for consumer direction to elect to direct and manage (or to have a representative 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) and for ECF CHOICES, the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service.

Contract Provider - A Provider that is employed by or has signed a provider agreement with the CONTRACTOR to provide Covered Services.

Contractor Risk Agreement (CRA) – The Contract between the CONTRACTOR and TENNCARE regarding requirements for operation and administration of the managed care TennCare program, including CHOICES and I/DD MLTSS Programs.

Dispute Resolution Process - The processes set forth in the Provider Manual to resolve disputes between the parties, including the Provider Dispute Resolution Process and the Medical Management Corrective Action Plan. In addition, the TennCare Provider Independent Review of Disputed Claims process shall be available to Providers to resolve claims denied in whole or in part by BCT as provided at Tenn. Code Ann. § 56-32-126(b).

Electronic Visit Verification (EVV) System – An electronic system that meets the minimum functionality requirements prescribed by TENNCARE which provider staff must use to check-in at the beginning and check-out at the end of each period of service delivery to monitor Member receipt of specified CHOICES, ECF CHOICES, and 1915 (c) waiver HCBS and which may also be utilized for submission of claims. Any such system shall comply with the 21st Century Cures Act.

Eligible ECF CHOICES HCBS – Personal assistance, supportive home care, hourly respite, community transportation, and/or any other ECF CHOICES HCBS specified in TennCare rules as eligible for consumer direction which an ECF CHOICES Member is determined to need and elects to direct and manage (or have a representative 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) and the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service. Eligible ECF CHOICES HCBS do not include home health, private duty nursing services, or Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS).

Employer of Record – The Member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or a representative designated by the Member to assume the consumer direction of eligible CHOICES or ECF CHOICES HCBS functions on the Member's behalf.

Employment and Community First (ECF) CHOICES - A managed long-term services and supports program that offers home and community-Based services to eligible individuals with intellectual and developmental disabilities enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES or ECF CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES and ECF CHOICES HCBS are eligible for Consumer Direction. CHOICES and 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 such services are subject to estate recovery and shall 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 cost neutrality cap. The cost of home health and private duty nursing shall also be counted against the Member's Expenditure Cap for Members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap Based on exceptional medical and/or behavioral needs.

I/DD MLTSS Programs – Long-term services and supports for individuals with intellectual or developmental disabilities delivered through the managed care program; refers collectively to the ECF CHOICES program, 1915(c) HCBS waivers, and ICF/IID services.

Integrated Support Coordination Team (ISCT) – For purposes of ECF CHOICES Groups 7 and 8, the team consisting of the Member's Support Coordinator and the Behavior Supports Director as defined in

2.29.1.3.6 or a similarly qualified behavior supports professional, who shall be responsible for performing in close collaboration the required Support Coordination functions as specified in this Contract, including (but not limited to) comprehensive initial and ongoing assessments, development and implementation of the PCSP, monitoring progress and outcomes, and transition planning

Interagency Review Committee – The committee composed of staff from TennCare and DDA that reviews requests submitted on behalf of a Potential Applicant in order to determine whether the Potential Applicant meets reserve capacity criteria for ECF CHOICES as defined in TennCare Rule 1200-13-01-.02 or in Operational Procedures submitted to CMS. Except for individuals with ID or DD who have an Aging Caregiver or as otherwise specified by TennCare, a determination by the Interagency Review Committee that a Potential Applicant meets reserve capacity criteria shall be required before DDA or an MCO proceeds with an enrollment visit to determine if the Potential Applicant qualifies to enroll in ECF CHOICES in a reserve capacity slot designated for such purpose.

Long-Term Care Ombudsman Program – A statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-Based residential alternatives developed by the State. The Ombudsman is available to help these individuals and their families resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the Department of Disability and Aging (DDA).

Katie Beckett Part A Member – A TennCare Enrollee who has been enrolled by TennCare into Part A of the Katie Beckett Program.

Katie Beckett Part A Program – One of two components of Tennessee's Katie Beckett Program that services a limited number of children with the most significant disabilities or complex medical needs who meet institutional level of care, as established by TennCare, and who qualify for Medicaid only by waiving the deeming of parents' income and/or assets to the child.

Medical Necessity or "Medically Necessary" - Medical Necessity and Medically Necessary as used in this Agreement shall have the meaning contained in Tenn. Code Ann. § 71-5-144 and TennCare Rule 1200-13.16.

Medical Records – All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

Managed Long-Term Services and Supports (MLTSS) - The delivery of long-term services and supports through Medicaid managed care programs

Money Follows the Person (MFP) Provider Incentive-

- Financial Incentives will be made available for MCOs to provide funding directly to HCBS providers that are actively engage in transformation practices to create more opportunities for person centered service delivery that results in greater independence and community living for persons supported in accordance with the approved MFP Capacity Building grant. Providers will be granted funding for developing and implementing strategies to divert people from institutionalized settings, transition individuals to integrated community living, and expand community living supports.
- The Provider guarantees that the BlueCare Tennessee application for participation ("Application") has been accurately completed and that any supporting documentation, including detailed budget and current staffing model, shall be accurately completed, and returned by applicable timelines. In Tennessee's Money Follows the Person (MFP) Demonstration, the Division of TennCare is partnering with the MCOs to support individuals with intellectual and developmental disabilities (I/DD) transition out of institutionalized settings and into integrated community settings.
- All proposals submitted must include appropriate criteria and substantiating evidence to support outcomes and impacts. Providers will provide only those services that the Provider is duly

licensed, credentialed, and professionally/technically qualified to provide and will otherwise abide by the terms of their Provider Agreement and implement expansion activities in accordance to the approved proposal and timelines.

- Upon acceptance Providers shall execute expansion activities and provide approved services to a Member as indicated in the Member's PCSP, the Provider shall ensure that it has staff sufficient to provide the product(s) or service(s) authorized by BlueCare Tennessee in accordance with the Member's PCSP, including the amount, frequency, duration, and scope of each service in accordance with the Member's service schedule.
- Outcomes are subject to ongoing monitoring/auditing to determine changes/improvements resulting from the approved funded project.
- For additional information contact your provider network manager at CHOICESproviderrelations@BCBST.com

Non-Contract Provider – Any Provider that is not directly or indirectly employed by or does not have a provider agreement with the CONTRACTOR or any of its subcontractors pursuant to the Contract between the CONTRACTOR and TENNCARE.

Non-Discrimination Provisions – No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in the contract risk agreement in Section A.2.3.5, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with BlueCare or in the employment practices of the provider. The provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.

The provider shall be interacting 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, therefore, the provider shall have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures, and for regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equity and eliminate bias with generating assessment results. The provider's staff members carrying out the terms of the provider agreement shall 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. The provider entity's new hires carrying out the terms of the provider agreement shall receive this training within thirty (30) days of joining the entity's workforce.

The provider 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. The provider agrees 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 the provider 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 the member's MCO if the member needs assistance with filing a complaint.

Electronic and Information Technology Accessibility Requirements. To the extent that the provider is using electronic and information technology to fulfill its obligations under this Contract, the provider agrees 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, the provider 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/).

Non-Reportable Event - An event as defined at Section A.2.12.22 which the contracted Provider is not required to report to the CONTRACTOR or DDA, but which the Provider shall be responsible for documenting, addressing, tracking and trending in order to prevent similar occurrences in the future whenever possible.

Person-centered support planning – An individual-directed process that may include a representative whom the individual has freely chosen, and others chosen by the individual to contribute to the process. This process may also include a court appointed legal representative. This is a positive approach to the planning and coordination of services and supports Based on individual aspirations, needs, preferences, and values in a manner that reflects individual preferences and goals. The goal of person-centered support planning is to create a plan that optimizes the person's self-defined quality of life, choice, and control, and self-determination through meaningful exploration and discovery of unique preferences, needs and wants in areas including, but not limited to, health and well-being, relationships, safety, communication, residence, technology, community, resources, and assistance. The person must be empowered to make informed choices that lead to the development, implementation, and maintenance of a flexible service plan for paid and unpaid services and supports in the most integrated setting that reflects personal preferences and choices.

Prior Authorization - The act of authorizing specific services or activities before they are rendered or occur.

Religious and Ethical Directives - For a Provider Agreement that includes Ethical and Religious Directives, or when a provider has conscience and religious beliefs that prevents them from providing certain TennCare covered services due to those beliefs, include the following requirements:

The Provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives, or its conscience and religious beliefs, to the contractor. The CONTRACTOR shall furnish this list to TENNCARE, notating those services that are TennCare covered services. This list shall be used by the CONTRACTOR and TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives or its conscience and religious beliefs.

Self-Direction of Health Care Tasks – A decision by a CHOICES or ECF CHOICES Member or their legal representative to direct and supervise a paid worker delivering eligible CHOICES or ECF CHOICES HCBS in the performance of healthcare tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather healthcare-related duties and functions (such as administration of medications) that a CHOICES or ECF CHOICES Member may elect to have performed by a paid worker as part of the delivery of eligible CHOICES or ECF CHOICES HCBS s/he is authorized to receive.

Service Agreement – The agreement between a CHOICES or ECF CHOICES Member or their legal representative electing consumer direction of HCBS (or the Member's representative) and the Member's consumer-directed worker that specifies the roles and responsibilities of the Member (or the Member's representative) and the Member's worker.

SMART Goals - As it pertains to person-centered support planning, a mnemonic or acronym which provides a framework to develop and articulate person-centered goals in which the goals are specific, measurable, attainable, relevant, and time bound.

Support Coordinator The individual who has primary responsibility for performance of support coordination activities for an ECF CHOICES Member as specified in the CRA and who meets the qualifications specified in the CRA.

Provider Requirements:

1. The Provider will provide only those services that the Provider is duly licensed, credentialed, and professionally/technically qualified to provide and will otherwise abide by the terms of an executed Agreement and any applicable attachments. The Provider will use its best efforts to provide Covered Services in a competent and timely manner. In addition, the Provider agrees

to provide services in accordance with the terms of their executed agreement and pursuant to the Member approved, written PCSP.

2. The Provider will be issued a copy of the Member's PCSP and agrees to provide the Covered Services as noted in the PCSP.
3. All Providers shall ensure that services provided are ordered in the PCSP. Each PCSP shall describe the products or services to be furnished, the frequency and duration of each product or service, and the Provider type required to furnish each product or service. All services shall be furnished pursuant to an approved written, PCSP. The Provider shall not bill BlueCare Tennessee or the Member, for products or services furnished prior to the issuance of the PCSP or products or services not included in the PCSP.
4. The Provider shall be prohibited from requiring a Member to choose the Provider as a provider of multiple products or services as a condition of providing any service.
5. Provider is prohibited from soliciting Members to receive services from the Provider including: (i) referring an individual for CHOICES or ECF CHOICES screening and intake with the expectation that, should CHOICES or ECF CHOICES enrollment occur, the Provider will be selected by the Member as the service Provider; or (ii) communicating with existing CHOICES or ECF CHOICES Members via telephone, face-to-face or written communication for the purpose of petitioning the Member to change Providers; and (iii) communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHOICES or ECF CHOICES Members that should instead be referred to the person's MCO or Area Agency on Aging and Disability, or DDA, as applicable.
6. Provider shall provide advance written notice to BlueCare Tennessee before voluntarily terminating the agreement and specify the timeframe for providing such notice.
7. Provider shall notify BlueCare Tennessee immediately if Provider is considering discharging a Member. Provider must consult with the Member's Support Coordinator to intervene in resolving the issue if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate.
8. Provider shall notify the Member in writing prior to discharge in accordance with state and federal requirements.
9. Provider shall accept payment or appropriate denial made by BlueCare Tennessee (or, if applicable, payment by BlueCare Tennessee that is supplementary to the Member's third party payer) plus the amount of any applicable patient liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from the Member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse, or any other legally responsible person of the Member being served.
10. The Provider shall assure that all applicable standards of any licensure or certification requirements are met. All Providers shall be at least eighteen (18) years of age and shall not have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare Program.
11. ECF CHOICES HCBS Providers must submit copies of current licensure and/or certification (as applicable) to BCT.

    a. For CLS1 and CLS2 services, the Provider is required to be licensed by DDA as ID & DD Semi-Independent Living Services Facility in accordance with licensure regulations.
    b. For CLS3 services, the Provider is required to be licensed as ID & DD Supported Living or Residential Habilitation Facilities Provider by DDA in accordance with licensure requirements.

    For all CLS and CLS-FM services, the Provider is required to be licensed by DDA as ID & DD Placement Services Facility in accordance with licensure regulations and must also be contracted with DDA to provide residential services in at least one of the State's 1915(c) waivers for individuals with intellectual disabilities, and actively providing residential services.
12. The Provider, unless it is a subdivision of the State of Tennessee, and any subcontractor retained for the purpose of providing any services shall secure all necessary liability and worker's compensation insurance coverage as necessary to adequately protect Members and BCT. Providers must obtain written approval from the MCO for a subcontract that is for the purposes of providing TennCare covered services pursuant to your provider agreement with the MCO. The word "subcontract" here has its usual legal meaning. Failure by the provider to

obtain by the MCO written approval may lead to the contract being declared null and void by the MCO. Claims submitted by the subcontractor or by the provider for services furnished by the unapproved subcontractor are improper payments and may be considered false claims. Any such improper payments may be subject to action under Federal and State false claims statutes or be subject to be recouped by the MCO and/or TENNCARE as overpayment, under an executed Provider Agreement.

13. All Providers utilizing the EVV System shall have adequate EVV staff to monitor the EVV System on a daily basis. At a minimum, such Provider shall have at least one full time staff person devoted to EVV System monitoring and two staff persons fully trained and knowledgeable of the EVV System and its functionality. Additionally, such Provider shall ensure that all HCBS workers complete and submit worker surveys upon logging out of each visit using a format and, in a manner, previously approved by TennCare.
14. The Provider shall notify BCT in writing at least sixty (60) days prior to the date of the proposed termination of services to the Member. Prior to discontinuing service to the Member or prior to Provider termination of its Provider Agreement, as applicable, the Provider shall be required to

    Provide a written notification of the planned service discontinuation to the Member, his/her conservator or guardian, and his/her support coordinator, no less than thirty (30) days prior to the proposed date of service or Provider Agreement termination. Obtain BlueCare'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 BlueCare 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.
15. Contracted Providers in CHOICES and ECF CHOICES are responsible for acquiring, developing, and deploying a sufficiently staffed and qualified workforce to capably deliver services to Members 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, and duration of services specified in the PCSP, and shall be responsible for arranging back-up staff to address instances when other scheduled staff are not able to deliver services as scheduled. The Provider shall, in any and all circumstances, except Member refusal of continuation of services, instances where the Member's health and welfare would be otherwise at risk by remaining with the current Provider, if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm, or following termination of the Agreement, continue to provide services that maintain continuity of care to the person supported in accordance with his/her PCSP until other services are arranged and provided that are of acceptable and appropriate quality. BlueCare 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 worker will result in services not being delivered.
16. Contracted providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment. The MCO shall provide targeted information to providers regarding the use of psychotropic medications for individuals with I/DD, including information regarding other non-pharmacological interventions, as appropriate.
17. The Provider shall have written procedures for the provision of language assistance services to Members and/or the Member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any Member and/or the Member's representative who need such services, including but not limited to, Members with Limited English Proficiency and individuals with disabilities.
18. Provider is prohibited from reproducing for its own use the CHOICES or MFP logos unless Provider has submitted a request to BCT to do so and BCT has obtained prior written approval from TennCare in accordance with Section A.2.17 of the CRA.

Person-Centered Support Plan (PCSP) – Person-Centered Support Plan (PCSP) – As it pertains to ECF CHOICES, the PCSP is a written plan developed by the Support Coordinator in accordance with

Section A.2.9.6.6.2, using a person-centered support 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 to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the CONTRACTOR and other payor sources). The initial planning process is directed by the Member with long-term support needs unless he or she has a court-appointed guardian or conservator and may include a representative whom the Member has freely chosen to assist the Member 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 in achieving a personally defined lifestyle and outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth.

System of Support (SOS) – A comprehensive person-centered approach to the delivery of Behavioral Crisis, Prevention, Intervention, and/or Stabilization services (see Section A.2.7.2.8.4) for individuals with I/DD who experience challenging behaviors that place them and/or others at risk of harm with a primary focus on coordination of services and supports, improved linkages, and increased capacity of paid and unpaid caregivers to prevent, stabilize, and manage crisis events in order to empower individuals with I/DD to live the lives they want in their communities.

Technology Providers (Enabling) - providers that support CHOICES members with a technology service are required to meet all specified requirement within executed provider agreements. Technology providers are not required to provide emergency services or render services without the requirement of prior authorization of any kind specific to prenatal services, CLIA, hospital protocols, reimbursement for obstetric care, pharmacy, or PBM. Providers of assistive technology and enabling technology must carry adequate liability and other appropriate forms of insurance coverage that must be reasonable and approved by the credentialing MCO.

Tennessee Department of Disability and Aging or DDA– The state agency having the statutory authority to plan, promote, provide and support the delivery of services for persons with intellectual and developmental disabilities, and which serves as the contracted operating agency for the state's 1915(c) HCBS Waivers and is responsible for the performance of contracted functions for ECF CHOICES as specified in interagency agreement.

I. ECF CHOICES Provider Contracting/Credentialing

DDA is responsible for the initial and recredentialing of all ECF providers. BlueCare coordinates/collab orates with DDA as applicable.

BlueCare Tennessee's ECF CHOICES program for Employment and Community First Services ensures that all contracted Providers are initially credentialed and re-credentialed to remain network ECF CHOICES Providers. The process meets the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs. In addition, BlueCare Tennessee ensure that all ECF Providers, including those credentialed/re-credentialed in accordance with NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations (MCOs), meet applicable State requirements, as specified by TENNCARE in State Rule, the Contractor Risk Agreement (CRA), or in policies or protocols.

Credentialing occurs initially during the application process for any ECF CHOICES Provider applying to participate in the ECF CHOICES Network. Once a Provider is approved to participate in the network, they must be re-credentialed Based on the service types that each ECF CHOICES Provider provides. For ongoing ECF CHOICES Providers, they must be re-credentialed at least annually: Employment Services and Supports, Benefits Counseling, Community Integration Supports Services, Community Transportation, Independent Living Skills Training, Personal Assistance, Community Living Supports, Community Living Supports Family-Model, Specialized Consultation and Training, Respite, Supportive Home Care, Peer-to-Peer Self Direction, Community Support Development, Organization and Navigation, Conservatorship and Alternatives to Conservatorship, Health Insurance Counseling (Forms Assistance) and Family to Family Support. All other ECF CHOICES Providers (minor home modifications and assistive technology) must be re-credentialed, at a minimum, every three (3) years.

ECF CHOICES Providers that are contracted and enrolled in the network must be compliant with the HCBS Settings Rule and Person-centered support planning to ensure Medicaid-funded HCBS are provided in settings that are non-institutional in nature. BlueCare Tennessee ensures that contracted Providers deploy services that reflect Member needs, preferences, and goals. Through credentialing of first time Providers, and re-credentialing of established Providers, BlueCare Tennessee ensures that HCBS settings core indicators are met and sustained. The standards that are measured and are requirement for compliance, network entrance and retention are:

1. **Integration** in the greater community.
2. **Choice** of service settings and Providers that provide the services in the setting.
3. **Rights** to privacy, dignity, respect and freedom from coercion.
4. **Independence** that optimizes personal initiative and autonomy.

Compliance for the HCBS Settings Rule is measured during the mandatory credentialing schedule and conducted on-site visit. Providers must demonstrate ongoing compliance to these rules and confirm with signature through attestation on the Standards Assessment and Documentation Review Tool.

MCOs are required to maintain a network of contracted providers for ECF CHOICES that is adequate to ensure choice of Providers, to meet the needs of each and every Member enrolled in the program, and to provide authorized ECF CHOICES HCBS. This includes initiating services in the Member's person-centered supports plan within the prescribed timeframes specified in the contract and in ECF CHOICES protocols, and continuing services in accordance with the Member's person-centered supports plan, including the amount, frequency, duration, and scope of each service in accordance with the Member's service schedule. The following are "preferred contracting standards" that MCOs will apply in contracting with providers for ECF CHOICES:

- The Provider currently participates in one or more of the Section 1915(c) waiver programs for individuals with I/DD and has a consistent Quality Assurance (QA) performance rating of "proficient" or "exceptional performance." Providers with "exceptional performance" shall be given additional consideration. For the purpose of this Section, consistent QA performance shall mean that the provider receives the ratings of performance described above for at least two (2) consecutive years, including the most recent survey results.
- The Provider has or is actively seeking (meaning applied for and has financially invested in the process) accreditation from a nationally recognized accrediting body, e.g., Commission on Accreditation of Rehabilitation Facilities (applicable only if accredited for the specific services the Provider will provide in ECF CHOICES), Council on Quality and Leadership (CQL), and the Council On Accreditation (COA). Acceptance of accreditation from other entities not listed must be prior approved by TENNCARE.
- The Provider has a Vocational Rehabilitation Letter of Agreement with the Tennessee Department of Human Services, Division of Rehabilitation Services.
- The Provider has completed DDA person-centered organization training.
- The Provider has achieved documented success in helping individuals with I/DD achieve employment opportunities in integrated community settings at a competitive wage. Such success may be Based on the number or percent of persons served that the Provider has successfully placed in integrated employment settings who are earning a competitive wage; success in developing customized employment options for individuals with more significant physical or behavior support needs; or other employment successes the CONTRACTOR determines merit additional contracting consideration.
- The Provider has demonstrated leadership in employment service delivery and community integration, e.g., designing and implementing plans to transition away from Facility-Based day supports to integrated employment services with community-Based wraparound supports.
- The Provider can demonstrate longstanding community relationships that can be leveraged to assist Members in pursuing and achieving employment and integrated community living goals, including commitments from such community-Based organizations to work with the Provider in order to help persons supported by the Provider to achieve such goals.
- The Provider has assisted persons supported by the agency in successfully transitioning into more independent living arrangements, such as Semi-Independent Living.
- The Provider has policies and systems in place to support Member selection of staffing and consistent staffing assignment, which are implemented and monitored.

- The Provider has capacity and willingness to function as a health partner with choice agency in order to support Member participation in staff selection and supervision, including appropriate clinical and case management staffing to support ongoing assurance of appropriate preventive care and management of chronic conditions.
- The Provider is willing and able to assign staff who are linguistically competent in spoken languages other than English that may be the primary language of individuals enrolled in ECF CHOICES and/or their primary caregivers. The Provider is able to assign staff that are trained in the use of auxiliary aids or services in order to achieve effective communication with individuals enrolled in ECF CHOICES and/or their primary caregivers.
- The Provider employs a Certified Work Incentive Coordinator (CWIC) who is available to counsel Members on benefits and employment.
- The Provider employs or contracts with appropriately licensed professionals in one (1) or more specialty areas (behavior services, occupational therapy, physical therapy, speech language pathology, nutrition, orientation and mobility, or nurse education, training and delegation) to assist paid staff in supporting individuals who have long-term intervention needs, consistent with the PCSP, therefore increasing the effectiveness of the specialized therapy or service, and allows such professionals to be an integral part of the person-centered support planning team, as needed, to participate in team meetings and provide additional intensive consultation for individuals whose functional, medical or behavioral needs are determined to be complex.
- The Provider meets other standards established by TennCare in policy or protocol that are intended to confer preferred contracting status.

DDA is responsible for the credentialing of ECF Providers and shall include the collection of required documents and verification that the Provider:

1. 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;
2. Attained an acceptable outcome for recent inspections or monitoring from licensing agencies as applicable;
3. Is not excluded from participation in the Medicare or Medicaid programs;
4. Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE;
5. Possesses General and/or Professional Liability insurance with acceptable limits;
6. Has policies and processes in place to conduct and evaluate, in accordance with federal and state law and rule and TENNCARE policy, criminal background checks, which shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry and National Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE), on all prospective employees who will deliver ECF CHOICES HCBS and to document these in the worker's employment record; Additionally, has policies and procedure to check the LEIE monthly on an ongoing basis for each worker; also has within the policy that screening of employees and contractors occur prior to the performance of their duties and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The Provider shall also be required to have an individual assessment policy for assessing potential employees whose criminal background check reveals past criminal conduct of the kind not subject to exclusion or debarment by state and federal law. The Provider shall be required to immediately report to BlueCare Tennessee any exclusion information discovered. The Provider shall be informed by BlueCare Tennessee that civil monetary penalties may be imposed against Providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare Members; and
7. Has a process in place to provide and document initial and ongoing education to its employees who will provide services to ECF CHOICES Members that includes, at a minimum:

    - Orientation to the population that the staff will support (elderly and disabled population; adults with physical disabilities, individual with I/DD);
    - Disability awareness and cultural competency training, including person-first language etiquette when meeting and supporting a person with a disability;

- Ensure that your agency has the capability to ensure physical access, reasonable accommodations, and accessible equipment for furnishing of services to individuals supported with physical or mental illness,
- Ethics and confidentiality training, including HIPAA and HI-TECH;
- Delivering person-centered services and supports, including Federal HCBS settings requirements and the importance of the Member's experience;
- Working with family members and/or conservators, while respecting individual choice;
- An introduction to behavioral health, including behavior support challenges, individuals with I/DD or other cognitive limitations (including Alzheimer's disease, dementia, etc.);
- The paid caregiver's responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions;
- Abuse, neglect and exploitation prevention, identification, and reporting;
- Reportable event identification management and reporting;
- Documentation of service delivery;
- Deficit Reduction Act information regarding False Claim Act and detecting fraud, waste and abuse;
- Community Living Supports;
- Use of the EVV System; and
- Any other training requirements specified by TENNCARE in State Rule, or in policies or protocols.

8. Has policies and processes in place to ensure:

    - Compliance with BlueCare Tennessee's reportable event reporting and management process;
    - Appropriate use of the EVV system;
    - Documentation, retention, and disclosure of enrollee specific data;
    - Documentation, retention, and disclosure of service delivery;
    - Deficit Reduction Act: False Claim Act and detecting fraud, waste, and abuse;
    - Community Living Supports; and
    - Compliance with the Person-centered support planning and HCBS Settings Rule.

At a minimum, re-credentialing of ECF Providers shall include verification of continued licensure and/or certification (as applicable), and compliance with policies and procedures identified during credentialing, including background checks, LEIE and other registry checks, training requirements, reportable event reporting and management, and use of the EVV.

Personal Care Service Providers must maintain written policies and procedures of their business model. The policies 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. BlueCare shall have provisions in its Compliance Plan to perform a coordinated audit of a sampling of Personal Care Service Providers to be submitted annually to TennCare with the Compliance Plan. Upon initial credentialing, and annual recredentialing, thereafter, BlueCare shall verify required policies and procedures are implemented.

For both credentialing and re-credentialing processes, ECF staff shall conduct a site visit. If the Provider is located out of state, BlueCare Tennessee ECF CHOICES may waive the site visit and perform a documentation audit in lieu of the on-site visit documenting the reason in the Provider file. During the site visits conducted for each ECF Provider type, BlueCare Tennessee will document and verify compliance with all requested documentation. The tools used to identify potential deficiencies during the credentialing and re-credentialing process include, but are not limited to, the following:

- ECF BlueCare application
- ECF CHOICES Rep Checklist
- ECF CHOICES Enrollment Checklist
- Credential Statement of Attestation for Organizational Providers
- Standards Assessment; and Documentation Review Form

If documents are not available at the time of the on-site audit, BlueCare Tennessee Provider Network Manager records the missing documents in the comment section of the ECF CHOICES Site Visit Report. The Provider will be placed on a Corrective Action Plan (CAP) and will have fourteen (14) days to submit the missing information. The Provider will be instructed to provide the missing documentation and of the obligation to supply the documentation by the due date established at the time of the on-site visit. The Provider may submit documents in the mutually agreed upon manner to include: e-mail, fax, mail, or hand-delivery.

If required documents are not submitted timely and/or not acceptable:

- New Providers/initial credentialing: the contract process will end.

The BlueCare Tennessee Provider contract permits either party to terminate the Provider Agreement or any applicable network Attachment with sixty (60) days prior written notice. Final decisions are determined via committee member vote and outcomes are documented in the committee meeting minutes. BlueCare Tennessee furnishes written notification to the Providers regarding the status of the credentialing or re-credentialing process. At a minimum, BlueCare Tennessee shall re-verify monthly that each ECF Provider has not been excluded from participation in the Medicare or Medicaid, and/or SCHIP programs.

Providers shall agree to carry adequate liability and other appropriate forms of insurance, which shall include, but is not limited to, the following:

- Workers' Compensation/Employers' Liability (including all State's coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers' liability.
- Comprehensive Commercial General Liability (including personal injury and property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate.
- Automobile Coverage (including owned, leased, hired, and non-owned vehicles coverage) with a bodily injury/property damage combined single limits not less than one million, dollars ($1,000,000.00). ECF CHOICES providers requiring this coverage are limited to those expected to transport the Member as a component of service delivery, as follows: individual and small group employment supports (including pre-employment services), personal assistance, supportive home care, community integration support services, community transportation, independent living skills training, CLS, and CLS-FM.

Provider shall conduct ongoing supervision and monitoring of all direct support staff who provide home-Based services to ensure that such services are consistently provided in accordance with the Member's PCSP and with best practices, quality, and program requirements and standards. Monitoring of each direct support worker shall occur at least once per calendar month at random intervals and shall include at least quarterly unannounced visits and conversations with Members (and Members' families, as applicable), regarding the quality of the services provided, as well as any problems or concerns. Provider shall maintain documentation of monitoring visits, including observations and other information gathered, and any actions taken to address problems or concerns and improve the services provided to the Member, which shall be reviewed by BlueCare Tennessee as part of its re-credentialing processes.

All CHOICES and I/DD MLTSS Programs providers are required to allow DDA staff access to pertinent CHOICES and I/DD MLTSS Program member documentation in order for DDA to perform its oversight role (applicable in CHOICES for Reportable Event Management and Quality Monitoring for specified services).

All providers for CHOICES and I/DD MLTSS Programs are required to comply with DDA investigations as prescribed by TennCare protocol.

Note: Quality monitoring of CHOICES services by DDA shall include only CLS and CLS-FM.

Credentialing Requirements for ECF CHOICES Providers

(Note: This section applies to currently contracted ECF providers for recredentialing purposes until further notice)

Employment Services/Supports (Annual credentialing)

- Certified Employment Provider
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Benefits Counseling (Annual credentialing)

- Licensed CWIC/CPWIC/WIP-C, self-employed or Provider-employed
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Community Integrated Support Services (Annual credentialing)

- Licensed Day Habilitation Provider
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Community Transportation (Annual credentialing)

- Licensed Personal Assistant Provider or CD worker
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Independent Living Skills Training (Annual credentialing)

- Licensed Day Habilitation Provider
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Personal Assistant (Annual credentialing)

- Licensed Personal Assistant Provider as PSSA, or Home Care Organization or CD worker
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Community Living Supports & Family Model (Annual credentialing)

- Licensed as a DDA (SL or ML or Res Habilitation Provider)

- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Assistive Technology/Enabling Technology (Recredentialing every 3 years)

- Licensed as DME or other wholesale or business entity
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Minor Home Modification (Recredentialing every 3 years)

- Licensed as Service Agency, building supplier, contractor, carpenter, craftsman or DME supplier (no subcontractors)
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Specialized Consultation and Training (Annual credentialing)

- Licensed professional or qualified AT professional
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Respite (Annual credentialing)

- Licensed as PSSA or Home Care Organization or CD worker
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Supportive Home Care (Annual credentialing)

- Licensed as PSSA or Home Care Organization or CD worker
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) (Annual credentialing)

- Licensed personal assistance Providers as PSSA
- Outpatient Mental Health License

- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Community Support Development, Organization and Navigation (Annual credentialing)

- Licensed as Community Navigator
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Change of Ownership (CHOW)

A CHOW occurs when there is a change in ownership, including either a change in individual owners, corporations, or general partnerships (e.g., a new partnership agreement would constitute a CHOW).

Buyers considering a CHOW must notify TennCare and Managed Care Organizations (MCOs) **at least sixty (60) days prior** to the anticipated effective date of the CHOW. Failure to notify the MCOs at least sixty (60) days prior to the effective date of the CHOW may result in claim payment delays.

If there are changes to the proposed CHOW effective date or the transaction is not completed, the buyer must notify TennCare and TennCare MCOs as soon as possible of either the change in the effective date or cancellation of the proposed CHOW. When a Buyer assumes the existing MCO Provider Agreement, all buyers must sign both a participating agreement with the State and a provider agreement with the MCOs to allow participation in the Medicaid program. To expedite the CHOW process, the State requires that MCOs have a provider agreement in place with the buyer – either a newly executed contract or assignment of the previous contract – prior to the effective date of the CHOW.

If the buyer assumes the existing MCO provider agreement, the buyer receives benefits such as any underpayments discovered after the CHOW. However, the buyer also assumes all penalties and sanctions under the MCO program, including repayment of any accrued overpayments discovered, regardless of who had ownership of the provider agreement at the time of the overpayment **unless** fraud was involved. If fraud is involved, in any fiscal year the seller had assignment, responsibility for the repayment of fraudulent overpayments remains with the seller.

If the seller refuses to assign, or the buyer refuses to assume the existing MCO provider agreement, the buyer must enter into its own MCO provider agreement.

Claims Processing

Claims for dates of service by the Provider *on or after* the CHOW **must be filed using the NPI/Medicaid ID for the new owner**.

Claims for dates of service *prior to* the date of the CHOW will continue to be billed under the seller's NPI.

In the event the provider contract is terminated because of a change of ownership, BlueCare Tennessee shall remain obligated to pay for reimbursable services rendered prior to termination of the contract and that become due after the contract is terminated subject to timely filing requirements.

J. Billing and Reimbursement

ECF CHOICES-specific billing and reimbursement guidelines

NOTE: All rates are reimbursed at 100 percent of the applicable State ECF CHOICES rate.

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
Exploration for Individualized Integrated Employment	T2025 UA	969	Unit to be used as o/c Based payment unit. Outcome Based payment upon receipt of service log (dates; activities; duration of each activity) and acceptable written report using standardized template prescribed by TennCare. All required service elements must be completed within 60 calendar days. Written report due no later than 14 calendar days after last date of service (maximum 74 days from service start date).	No	1 X every 365 days
Benefits Counseling	T2025 UB T2025 U1 UB T2025 U2 UB	969	Units should be authorized per quarter hour. T2025 UB = up to 20 hours. Can be authorized once every 730 days. T2025 U1 UB = an additional 6 hours. Can be authorized 3/year. T2025 U2 UB = PRN. Up to 8 hours per PRN. Can be authorized 4/year.	No	
Exploration for Self-Employment	T2025 U7 UA	969	Unit to be used as o/c based payment unit. Outcome based payment upon receipt of service log (dates; activities; duration of each activity) and acceptable written report using standardized template prescribed by TennCare. All required service elements must be completed within 60 calendar days. Written report due no later than 14 calendar days after last date of service (maximum 74 days from service start date).	No	1 X 365 days
Discovery - Individual	T2025 U2	969	Unit to be used as o/c Based payment unit. Outcome Based payment upon receipt of service log (dates; activities; duration of each activity) and acceptable written profile using standardized template prescribed by TennCare. All required service elements must be completed within 90 calendar days. Written report due no later than 14 calendar days after last date of service (maximum 104 days from service start date).	No	1 X every 1095 days
Situational Observation and Assessment - Individual	T2025 U3	969	Unit to be used as o/c based payment unit. Outcome based payment. MCO may authorize up to 4 units (experiences) every 1095 days. Service to be completed within 30, but no more than 60 days upon initiation of each unit. Reimbursement may occur after each experience upon receipt of service log (dates; activities; duration of each activity) and acceptable written summary report due within 10 calendar days of experience being completed or 60 calendar days of service start date,	No	Max 4 units w/in 30 calendar days 1 X every 1095 days

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
			whichever is sooner. Can be authorized only once every 1095 days.		
Job Development Plan	T2025 U4	969	Unit to be used as o/c Based payment unit. Outcome Based payment upon receipt of service log (dates; activities; duration of each activity) and acceptable written plan using standardized template prescribed by TennCare. Service must be completed, and written plan submitted no later than 30 calendar days after service start date.	No	1 X every 1095 days
Self-Employment Plan	T2025 U5	969	Unit to be used as o/c Based payment unit. Outcome Based payment upon receipt of service log (dates; activities; duration of each activity) and acceptable written plan using standardized template prescribed by TennCare. Service must be completed, and written plan submitted no later than 90 calendar days after service start date.	No	1 X every 1095 days
Job Development Start Up	T2025 UA U1 T2025 UA U2 T2025 UA U3 T2025 UB U4 T2025 UB U5 T2025 UB U6 T2025 UE U1 T2025 UE U2 T2025 UE U3	969	Unit to be used as o/c Based payment unit. Outcome Based payment upon service recipient achieving the following milestones: Phase 1. Completing two calendar weeks of individualized, integrated employment; Phase 2. Completing six calendar weeks of individualized, integrated employment; Phase 3. Completing ten calendar weeks of individualized, integrated employment. Tier A: average 80 hours Tier B: average 60 hours Tier C: average 40 hours Payment Phases: Phase 1: 60% of hours Phase 2: 25% of hours Phase 3: 15% of hours	No	1 X every 365 days
Self-Employment Start Up	T2025 U1 UA US T2025 U2 UA US T2025 U3 UA US	969	Unit to be used as o/c Based payment unit. Outcome Based payment upon service recipient achieving the following milestones: Phase 1. Completing two calendar weeks of self-employment; Phase 2. Completing six calendar weeks of self-employment; Phase 3. Completing ten calendar weeks of self-employment. Payment Phases: Phase 1: 60% of hours Phase 2: 25% of hours Phase 3: 15% of hours	No	1 X every 365 days

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
Job Coaching - Individual-Wage Employment	T2019 and T2018 Refer to authorization	969	Person's acuity tier must be determined prior to authorization. Three possible acuity tiers. Reimbursement rate based on support hours needed as percentage of the supported employee's paid work hours and length of time person has held job. One of three rates is possible. SCs will have fillable worksheet that will calculate the units and unit rate to be authorized based on the model. INCENTIVE TO FADE BUILT INTO RATE MODEL.	No	Max 40 hrs. in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment
Job Coaching - Individual-Self-Employment	T2019 and T2018 Refer to authorization	969	Person's acuity tier must be determined prior to authorization. Three possible acuity tiers. Reimbursement rate based on support hours needed as percentage of the supported employee's paid work hours and length of time person has held job. One of three rates is possible. SCs will have fillable worksheet that will calculate the units and unit rate to be authorized based on the model. INCENTIVE TO FADE BUILT INTO RATE MODEL.	No	Max 40 hrs. in combination with other non-res hab if working in individual integrated self-employment; 50 if employed at least 30 hours in individual integrated self-employment.
Co-Worker Supports	T2019 U1 UB UP	969	Rate based on gross cost to employer for co-worker support (payment to co-worker plus applicable employer taxes), plus a flat .60 provider admin fee per 15 minute unit of co-worker support. Rate paid to worker cannot exceed the lesser of 50% of the co-workers current hourly wage or $12 per hour.	No	Max 40 hrs. in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment.
Career Advancement	T2025 U8 T2025 U9	969	Unit to be used as o/c Based payment unit. Two separate outcomes: 1. Written plan submitted and approved; 2. Person achieves career advancement objective and has been in new position or second job for a minimum of 2 weeks. Can be authorized only once every 1095 days. Exception: Only when o/c 1 was paid and o/c 2 was never achieved, o/c 1 and o/c 2 may be reauthorized a second time within 1095 days only if different Provider is used.	No	Unit to be used as o/c Based payment unit. Two separate outcomes. Outcome Based payment. Can be authorized only once every 1095 days. Exception: Only when

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
					o/c 1 was paid and o/c 2 was never achieved. Units may be reauthorized after a min of 365 days only if new/different Provider.
Supported Employment (Small Group - Max of 2 persons)	T2019 U2	969	Habilitation, supported employment, waiver; per 15 minutes	No	Max 30 hours/week in combination with other non-res hab services
Supported Employment (Small Group - Max of 3 persons)	T2019 U3	969	Habilitation, supported employment, waiver; per 15 minutes	No	Max 30 hours/week in combination with other non-res hab services
Transition from small group to individual employment - This is an **Incentive Payment**, not a 'service'.	T2025 U3 UB	969	Unit to be used as one-time incentive payment for successful and complete transition of person from small group SE to individual, integrated employment. Prior to the Provider being eligible for incentive payment, the Member must have a minimum of six months in small group employment support services and a minimum of seven consecutive months in employment in individual employment or self-employment.	No	1 unit per person/per Provider
Integrated Employment Path Services (Time-Limited Prevocational Training)	T2015 U1 T2015 U2	969	Habilitation, prevocational, waiver; per hour	No	Max 12 months with one possible 12 month extension (see service definition for details). Max 20 hours per week in combination with other non-res hab services; 30 hours in combination with other non-res hab services if receiving at

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
					least one employment service; 40 hrs. in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment.
Community Integration Support Services (subject to limitations specified in Attachment G)	T2021 T2021 U1 T2021 U1 UA T2028 U1 T2028 U2	969	T2021 and T2021 with modifiers to be used for services provided. T2028 plus modifiers to be used for cost of registration, materials and supplies for participation in classes, conferences, or club/association dues. U1 modifier signifies children under age 21. U2 modifier signifies adults 21 +. Allowable costs are maximums.	No	Max 20 hours per week in combination with other non-res hab services; 30 hours in combination with other non-res hab services if receiving at least one employment service; 40 hrs. in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment.
Independent Living Skills Training	T2021 U2	969	Day habilitation, waiver; per 15 minutes Note limitations on hours in combination with employment or other allowable non-residential services. This service to be provided 1:1	No	Max 20 hrs. /week in combination with other non-res hab services if not in employment services. Max 30 hours per week in combination with other non-res hab

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
					services including at least one employment service (not Individualized Integrated or Self-Employment); Max 40 hrs. / week in combination with other non-res hab services if in individual integrated employment; Max 50 hrs./week in combination with other non-res hab services if working in individual integrated employment at least 30 hours per week.
Personal Assistance	T1019 UA T1019 UC UA	570	Personal care; per 15 minutes Groups 5 and 6 only. T1019 UA for Provider Agency T1019 UC UA for Consumer Direction For CD only, if overtime is worked, add TU modifier NOTE: If multiple visits per day are necessary, utilize U1, U2, U3, U4, U5	Yes	215 hours/month applicable to Group 6 only; expenditure cap for Group 5 limits below 215 hrs./month
Community Transportation	T2002 T2003 UC	960	T2002 – Non-emergency transportation; per diem (for Provider agency use only) T2003 UC – to be authorized when reimbursing fare for use of public transit, taxi, paying someone for gas, etc. (monthly transportation budget). This code does not mean reimbursement is only made to a CD worker; it means the Member is consumer directing this budgeted amount.	Yes	Cost should be determined prior to authorization and the lesser of the two expenses must be used.
Community Transportation (CT) - Stand-Alone Transportatio	T2002 U1 T2002 U2 T2002 U3 T2002 U4	960	Non-emergency transportation; per diem Standard Ambulatory Unit Rate for Employment: (T2002 U1)	No	**Maximum** of two (2) one-way trips per day;

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
n Service Provided by Contracted Service Provider			Standard Ambulatory Unit Rate for Community Activities (T2002 U2) Wheelchair Accessible Unit Rate for Employment: (T2002 U3) Wheelchair Accessible Unit Rate for Community Activities: (T2002 U4)		**Maximum** of twelve (12) one-way trips per week for employment; **Maximum** of six (6) one-way trips per week for integrated community activities other than employment. **Combined maximum** of twelve (12) one-way trips per week.
Community Living Supports (CLS) CLS 1a CLS 1b CLS 2 CLS 3 CLS 4 Monthly Services CLS 1a CLS 1b	CLS 1a = T2033 U1 UA CLS 1b = T2033 U3 UA CLS 2 = T2033 U4 UA CLS 3 = T2033 U5 UA CLS 4 = T2033 U6 UA CLS 4 = T2033 U7 UA T2032 U1 UA T2032 U3 UA	960	1unit/day	No	1unit/day
Community Living Supports—Family Model (CLS-FM) CLSFM 1a CLSFM 1b CLSFM 2 CLSFM 3 CLSFM 4 Monthly Services CLS 1a CLS 1b	CLSFM 1a = T2016 U1 UA CLSFM 1b = T2016 U2 UA CLSFM2 = T2016 U3 UA CLSFM3 = T2016 U4 UA CLSFM 4 = T2016 U5 UA CLSFM 4 = T2016 U6 UA T2032 U1 UA T2032 U3 UA	960	1unit/day	No	1 unit/day
Transitional Community	CLS-BHCST 2a = T2016 U8 UA	960	MCOs may elect to authorize the transitional rate for a member in Group 5, when appropriate, even if the	No	CLS-BHCST 2a = for no

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
Living Supports-Behavioral Health Community Stabilization and Transition (CLSBHCST) CLS-BHCST2a CLS-BHCST 2b	CLS-BHCST 2b = T2016 U9 UA		expenditure cap would be exceeded, IF the member would otherwise be required to move to Group 6 for safety reasons. CLS-BHCST 2a = for no more than 90 days CLS-BHCST 2b = for no more than 90 additional days		more than 90 days CLS-BHCST 2b = for no more than 90 additional days
Transitional Community Living Supports-Community Stabilization and Transition (CLS CST)	T2016 U7 UA	960	MCOs may elect to authorize the transitional rate for a member in Group 5, when appropriate, even if the expenditure cap would be exceeded, IF the member would otherwise be required to move to Group 6 for safety reasons. CLS-BHCST 2a = for no more than 90 days CLS-BHCST 2b = for no more than 90 additional days	No	90
Transitional Community Living Supports-Emergency Placement (CLS-EPCST)	T2016 U7 UA	960	MCOs may elect to authorize the transitional rate for a member in Group 5, when appropriate, even if the expenditure cap would be exceeded, IF the member would otherwise be required to move to Group 6 for safety reasons. Authorized for 30 days with an ability to request an additional 30 days maximum	No	30 days with the ability to request an additional 30 days maximum.
Assistive Technology, Adaptive Equipment and Supplies	T2029 U4 97535 97755	590	97535 = Training for the use of Assistive Technology in the home 97755 = Assistive Technology assessment	No	$5000/year combined with Enabling Technology
Minor Home Modifications	S5165	590		No	$6,000/project; $10,000/year; $20,000/lifetime
Individual Education and Training	T2012	969	Units to be billed per pre-authorized occurrence of expense.	No	$500/year
Peer-to-Peer Support and Navigation for Person-centered support planning, Self-Direction, Integrated Employment/	T2013	969	Face to face and telephonic time can accumulate to equate to hour increments before billing whole hours. First visit must be face to face.	No	$1,500/lifetime

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
Self-Employment and Independent Community Living					
Specialized consultation and training	G0159 G0160 G0161 G0164 S9470 H2015 H2014 G0159 U1 G0160 U1 G0161 U1 G0164 U1 S9470 U1 H2015 U1 H2014 U1	942	G0159 = OT G0160 = PT G0161 = SLP G0164 = RN S9470 = Nutritionist H2015 = Behavioral Supports H2014 = Orientation and Mobility U1 modifier will be used for people in Group 6 receiving this service who are determined to have exceptional medical and/or behavioral needs. No more than 3 hours for assessment and plan development. Up to no more than 90 minutes per training/consultation session.	No	rates up to $5,000/year; U1 = 10,000/year if have exceptional needs
Adult Dental	HCPCS currently covered in HCBS waivers		Allowable HCPCS list will be provided separately.	No	$5,000/year; $7,500/three consecutive years
Respite	S5150 UA S9125 UA S9125 UB	660	Respite to be provided in a person's home or home of respite worker, not a group residential setting. Modifiers for multiple services in one day (for use with S5150 only): U1, U2, U3, U4, U5	Yes	216 hours/year OR 30 days/year
Supportive Home Care (SHC)	T1019 U2 T1019 UC	570	Personal care; per 15 minutes Group 4 only. To be authorized in same manner as Personal Assistance. NOTE: If multiple visits per day are necessary, utilize U1, U3, U4, U5 - skip U2 as it is already the associated modifier.	Yes	Subject to expenditure cap.
Family Caregiver Stipend in lieu of SHC	T1020 U1 T1020 U2	570	Unit shall be used to bill/reimburse on a monthly basis. U1 modifier signifies children under 18 years old. U2 modifier signifies 18+. Amount of stipend paid will be determined during the planning process and is Based on number of hours that services are needed.	No	U1 = $500/mo U2 = $1,000/mo
Community Support Development, Organization and Navigation	T2025 U5 UA	969	Authorized as a monthly unit.	No	

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
Family Caregiver Education and Training	T2012 UA	969	Units to be billed per pre-authorized occurrence of expense.	No	$500/year
Decision Making Supports	T2025 U1 SE T2025 U2 SE	969	T2025 U1 SE = Information/education session ($25/hour - individual face to face, not group setting). Must complete this one before can utilize lawyer or court fees. T2025 U2 SE = Lawyer fees: Typical billable rate up to a max of $250	No	$500/lifetime; information/education session required in order to access other service components Note: T2025 SE U3 end dated effective 12/11/2019 under WR29647, as court fees are no longer reimbursable.
Health insurance counseling/ forms assistance	T2025 SE	969		No	15 hours/year
Intensive Behavioral Family Centered Treatment, Stabilization and Supports (IBFCTSS) Base Rate	H2020 HI/HN Refer to authorization	969	H2020. HI.HN Therapeutic behavioral services, per diem. Integrated mental health and intellectual disability/developmental disabilities program. Bachelor's degree level) H0018- Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem. H0019 - Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem. H2020. HI.HN Therapeutic behavioral services, per diem. Integrated mental health and intellectual disability/developmental disabilities program. Bachelor's degree level) Months 1-3 Family centered assessment and planning Training of all paid and unpaid caregivers (ongoing as needed) Twice weekly F2F individual and family treatment by Masters level licensed BH professional Crisis response by IBSS	No	Each monthly group is limited to 90 days per calendar year

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
			(Intensive Behavioral Support Specialist) with support from Masters level licensed BH professional, and linkage to psychiatry as needed Follow-up review/update CS-CPIP as appropriate by Masters level licensed BH professional Months 4-6 Ongoing assessment and planning as needed Weekly F2F individual and family treatment by Masters level licensed BH professional Crisis response by IBSS (Intensive Behavioral Support Specialist) with support from Masters level licensed BH professional, and linkage to psychiatry as needed Follow-up review/update CS-CPIP as appropriate by Masters level licensed BH professional Months 7-9 Ongoing assessment and planning as needed Bi-weekly F2F individual and family treatment by Masters level licensed BH professional Crisis response by IBSS (Intensive Behavioral Support Specialist) with support from Masters level licensed BH professional, and linkage to psychiatry as needed Follow-up review/update CS-CPIP as appropriate by Masters level licensed BH professional Months 10-12 (and beyond, as appropriate) Ongoing assessment and planning as needed At least monthly F2F individual and family treatment by Masters level licensed BH professional Crisis response by IBSS (Intensive Behavioral Support Specialist) with support from Masters level licensed BH professional, and linkage to psychiatry as needed Follow-up review/update CS-CPIP as appropriate by Masters level licensed BH professional		
Intensive Behavioral Community Transition and Stabilization	H0018 HI U1 H0018 HI U2 H0019 HI	969	H0018- Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem. H0019 - Behavioral health; long-term residential (non-medical, non-acute	No	90 days per calendar year

Benefits	HCPCS/ Modifier	Revenue Code	Description	Consumer Direction	Limit
Services (IBCTSS)			care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem. Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) is a new benefit targeted primarily to providing short and long term intensive 24/7 community-based behavioral-focused transition and stabilization services and supports to assist adults aged 18 years and older with intellectual and/or developmental disabilities (I/DD) and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities.		
IBFCTSS Outcome-Based Transition Planning and Implementation This is an Incentive Payment, not a 'service'.	T2038 HI U4 UA T2038 HI U4 UB T2038 HI U5 UA T2038 HI U5 UB T2038 HI U6 UA T2038 HI U6 UB	969	Outcome-Based Transition Planning and Implementation Incentive payment for successful and complete transition of person to promote stabilization and tenure from IBFCTSS to another ECF CHOICES plan (CH4A, CH5A, CH6A). Incentive is payable in 2 phases (2 months and 6 months following transition) dependent on the number of months the recipient has been enrolled in IBFCTSS.	No	
IBCTSS Outcome-Based Transition Planning and Implementation This is an Incentive Payment, not a 'service'.	T2038-HI U1 UA T2038-HI U1 UB T2038-HI U2 UA T2038-HI U2 UB T2038-HI U3 UA T2038-HI U3 UB	969	Outcome-Based Transition Planning and Implementation Incentive payment for successful and complete transition of person to promote stabilization and tenure from IBCTSS to another ECF CHOICES plan (CH4A, CH5A, CH6A). Incentive is payable in 2 phases (2 months and 6 months following transition) dependent on the number of months the recipient has been enrolled in IBCTSS.	No	
Enabling Technology	A9279 A9279 V2 XP A9279 V3 XP A9279 V4 XP	590	$5000/year-combined with Assistive Technology (refer to Enabling Technology Protocol on TennCare website for details) A9279 = Specific ET items/services	No	$5000 annually combined with Assistive Technology

In addition to the benefits specified above, a person enrolled in ECF CHOICES Groups 4, 5, and 6 may receive short-term nursing facility care as Medically Necessary for up to ninety (90) days. A person enrolled in ECF CHOICES receiving short-term nursing facility care will not be 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 person enrolled in ECF CHOICES Groups 7 and 8 shall not be eligible to receive short-term nursing facility care.

When billing for services rendered to ECF CHOICES Members, Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS1500 professional and CMS 1450 facility health insurance claim forms and/or the appropriate electronic filing format. In addition to the following ECF CHOICES-specific billing guidelines outlined below, all BlueCare/TennCare*Select* billing guidelines apply (see Section V. Billing and Reimbursement, of this Manual).

The reimbursement rates and codes for ECF CHOICES are Based on methodology established by the Division of TennCare and will be updated according to the direction and at the discretion of the Division of TennCare. Only those HCPCS (CPT® and HCPCS Level II) codes on the fee schedule will be considered for reimbursement when filed in conjunction with the corresponding Revenue Code(s) and modifiers listed in the table below, otherwise charges will be denied for billing guidelines. **Services billed outside of the agreement are subject to recovery.** All services require prior authorization.

Providers must comply with the Affordable Care Act and TennCare policy and procedures, including but not limited to, reporting overpayments, the requirement to report Provider-initiated refunds of overpayments to BlueCare Tennessee and TennCare Office of Program Integrity (OPI) and, when it is applicable, return overpayments to BlueCare Tennessee within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law.

Note: Provider Preventable Conditions

No payment shall be made by BlueCare Tennessee ECF CHOICES to a Provider for Provider-preventable conditions as defined in 42 CFR § 434.6(a) (12) and §447.26. BlueCare Tennessee ECF CHOICES requires Providers to identify Provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

Refer to the *Claims Reference Guide* located at https://bluecare.bcbst.com/forms/Provider%20Forms/ECF_CHOICES_Claims_Reference_Guide.pdf.

Refer to General Billing information (Section V. Billing and Reimbursement) of this Manual for Home Health Agency and Private Duty Nursing billing guidelines.

Refer to Utilization Management Guidelines (Section VIII. Utilization Management Program) of this Manual for Member benefits limitations and authorization guidelines.

Electronic Billing Instruction

Facilities wishing to submit claims electronically can contact the BCBST eBusiness Solutions Department at:

Phone: 423-535-5717
Fax: 423-535-7523
E-mail: ecomm_support@bcbst.com

K. Member Grievances and Appeals

Grievances

When Members and their caregivers have problems or grievances about care or a service Provider, they should report this to the Support Coordinator at 1-888-747-8955. If the Support Coordinator cannot resolve the problem, or if the grievance is about the Support Coordinator, grievances should be escalated to the BlueCare Tennessee Support Coordinator's Supervisor or the ECF CHOICES Consumer Advocate. If BlueCare Tennessee is unable to resolve the problem or grievance, they may be escalated to the TennCare Solutions Unit, 1-800-878-3192.

Upon receiving a formal Member grievance, BlueCare Tennessee must respond to the complainant in writing within five (5) business days of receipt of the grievance. If the grievance can be resolved within the 5-day time period, the letter will include the resolution and basis for the resolution. If the grievance cannot be resolved, we will send a written notice to the grievant acknowledging receipt of the grievance.

The unresolved grievance will be reviewed, and a written follow-up response will be given to the grievant within thirty (30) calendar days. If the grievance involves abuse, neglect, or mistreatment, BlueCare Tennessee must notify the Division of TennCare at 1-877-224-0219 and, if appropriate, Department of Human Services/Adult Protective Services at 1-888-277-8366 in accordance with T.C.A. 71-6-103(b). Member grievances are documented in the CHOICES System of Record.

Appeals

An explanation of appeal rights is given to a Member upon enrollment in the ECF CHOICES program. When a service is denied, terminated, suspended, reduced, or delayed, the Member must be notified in writing by BlueCare Tennessee stating the reasons for the adverse action taken and include instructions how a Member can file an appeal and have a fair hearing. Providers of ECF CHOICES Members should also assist Members in the appeal process.

Members must be advised that if they file an appeal, they have the right to:

- have an attorney or someone else of their choice to speak for them;
- review information about why the service was denied, reduced, suspended, terminated, or delayed;
- present their evidence;
- ask questions of witnesses who are testifying during a hearing;
- ask for another medical opinion;
- have their services continued if they file an appeal within twenty (20) calendar days; and
- receive a written decision about the outcome of the appeal.

To appeal, a Member must respond within sixty (60) calendar days of the date he/she receives a letter informing him/her that a service has been denied, terminated, suspended, reduced, or delayed. An appeal form can be obtained from the TennCare Solutions Unit. If desired, an appeal can be submitted in any format. See Section VII. Member Policy of this Manual for detailed Member appeal instructions. Members can submit an appeal by mail, fax or phone.

Mail to:	TennCare Solutions Unit P O Box 00593 Nashville, TN 37202-0593	**Fax to:** **Call:**	1-888-345-5575 1-800-878-3192

Members may request help with their appeal if they have a health, learning, or language problem by asking for the assistance of the BlueCare Tennessee ECF CHOICES Consumer Advocate, or by calling:

Department of Disability and Aging (DDA)	1-877-236-0013
TennCare Solutions Unit	1-800-878-3192

Members having a hearing or speech problem and have a TTY/TDD machine, can call

1-800-772-7647 **(TTY/TDD ONLY).**

Non-Discrimination Reporting of ECF CHOICES Events

The following ECF CHOICES reportable event types must also be reported to BlueCare Tennessee:

- Allegations of disrespectful or inappropriate communication e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts that do not meet the definition of emotional or psychological abuse, but which are directed to or within eyesight or audible range of the person supported.
- Any instance of disrespectful or inappropriate communication, e.g. humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a person supported that is not directed to or within eyesight or audible range of the person supported and that does not meet the definition of emotional or psychological abuse.

These events can be submitted by mail or phone:

Mail to: BlueCare/TennCare*Select* Non-Discrimination Compliance Coordinator
1 Cameron Hill Circle
Chattanooga, Tennessee 37402

Call: 1-800-276-1978 for TennCare*Select* Members
1-800-468-9736 for BlueCare Members

L. Provider Appeal Process

See Section XII. Highlights of Provider/Subcontractor Agreement in this Manual for information on Provider payment disputes and independent reviews.

M. General Information

1. Criminal Background Checks and Registry Checks

Criminal background checks and registry must be conducted and evaluated by the Provider on its employees, subcontractors, volunteers and agents, prior to providing services, in accordance with state law and TennCare policy. Additionally, criminal background checks, ~~and~~ registry checks, and exclusion checks, as applicable, must be performed on any person who will have direct contact with a person receiving services in the CHOICES. At a minimum, criminal background checks, including registry checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry and National Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE), and TennCare's Terminated Provider List, Social Security Death Master File, SAM, If a potential employee or volunteer's name appears on any of the preceding registries, that individual is disqualified from providing services to a CHOICES or ECF CHOICES person. If a potential employee or volunteer's criminal background check returns results, the Provider must use its discretion as to whether that individual is appropriate to have direct contact with persons. If a potential employee's criminal background check returns results, the Provider must provide the potential employee with an individualized assessment, including results from criminal background checks, registries and exclusions, this individualized assessment must take into account 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 the manufacture, sale or distribution of drugs; and
c. The time that has passed since the offense or conduct and/or completion of the sentence.

Employees and volunteers who will not have direct contact with persons, but will have incidental contact only, must have registry checks for all registries listed above, but do not require criminal background checks. Appearance on any registry disqualifies an individual from having incidental contact with a person. Such registry checks must be performed prior to any employee or volunteer having any incidental contact with the person. For all volunteers and employees who qualify to provide services constituting only incidental contact with persons, the CHOICES Provider shall maintain proof that required registry checks were completed for MCO review during credentialing and re-credentialing visits, as requested.

The FEA shall be responsible for conducting criminal background checks and registry checks on its staff, its subcontractors, and consumer-directed workers. Additionally, all direct support employees hired after 1/1/17 must have all required criminal background checks and registry checks completed prior to serving any ECF CHOICES Member. Proof of these criminal background checks and registry checks must be identified during initial and recredentialing site visits and documented in all new hire files. Providers that are non-compliant will be subject to corrective action and/or disqualification from the contracting process.

The FEA is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers, or anyone acting for or on behalf of the CONTRACTOR conducts criminal background checks and registry checks in accordance with state law and TennCare policy. At a minimum, registry checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry and National Sexual Offender Registry, Social Security Death Master File, and List of Excluded Individuals/Entities (LEIE). The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers. Criminal background checks and registry checks must be performed on any employee or volunteer who will have direct contact with a member in CHOICES, ECF CHOICES, or 1915(c) waivers. Any employee or volunteer supporting CHOICES, ECF CHOICES, or 1915(c) waiver members who will not have direct contact with these members must have required registry checks completed prior to

beginning this support. Unless federal or state laws prohibit individuals with certain criminal records from holding positions or engaging in certain occupations, an individual whose background check reveals past criminal conduct shall be given an opportunity to undergo an individualized assessment in accordance with the applicable laws and legal guidance.

2. Reportable Event Reporting

In HCBS programs, there are three (3) categories of Reportable Events: Tier 1, Tier 2, and Additional Reportable Events and Interventions. The type of Reportable Event dictates the reporting requirements and process that must be followed by the provider, BlueCare, and DDA, as outlined in the REM Operational Protocol.

Providers are to comply with the requirements specified in the REM Protocol and Definitions document.

3. Coordination with other Managed Care Organizations (MCOs)

For covered long-term services and supports for ECF CHOICES Members who are transferring from another MCO, the receiving MCO is responsible for continuing to provide covered long-term services and supports, including both ECF CHOICES HCBS authorized and nursing facility services, for a minimum of thirty (30) days without regard to whether such services are being provided by contract or non-contract Providers.

For a minimum of thirty (30) days after the Member's enrollment and thereafter, the receiving MCO shall not reduce the Member's services unless a support coordinator has conducted a comprehensive needs assessment and developed an initial support plan, and the receiving MCO has authorized and initiated ECF CHOICES HCBS in accordance with the Member's initial support plan.

N. BlueCare Provider Compliance Program

Providers contracted with BlueCare must adhere to the EVV compliance program in accordance with established metrics and required standards. BlueCare monitors and audits identified measurable elements to ensure Providers maintain requirements of the compliance program. Any enforcement and disciplinary process for violations of the program will be conducted in accordance with the guidelines outlined.

Additionally, all providers are required to comply with the 21st Century Cures Act, and any policies conveyed by BlueCare to safeguard programs and improve the process of Home Care. Providers must ensure that all employees entered in the EVV database to support members must include social security numbers as part of employee personal data.

Providers are responsible for timely and accurate submissions of EVV Missed and Late Visit Reports. Reporting must include appropriate reason codes when Members are not supported in accordance to the Person-Centered Support Plan (PCSP) as outlined in the approved authorizations. Providers must have associated mitigating action plans to avoid ongoing non-compliant service. Failure to adhere to any parts of EVV policies or compliance requirements will increase Provider corrective actions and/or liquidated damages.

Contracted Providers are responsible for all EVV record keeping, including any visit maintenance, prior to submitting a claim associated with the EVV record. Providers must ensure the highest quality of support to all members, through continuous and timely monitoring of services for assigned members with authorized services at all times. Providers are responsible for managing and monitoring their Direct Support Professionals (DSP) to ensure approved services are delivered as expected using mandated EVV systems and tools. Immediate attention and action is required by Providers when a Provider is considered non-compliant. Failure to achieve and maintain compliance as outlined in the assessment of liquidated damages on violations that occurred during the review period, the imposition of contract actions (including contract termination) and/or the corrective action plan process.

Providers should utilize EVV reports to monitor their performance and ensure they are meeting the compliance requirement relative to visit verification and adherence to the compliance standards. The reports can be accessed through the EVV database. Providers should validate the accuracy of claims prior to submissions, in accordance to the authorization effective for the date of service on the claim.

When paper time sheets reflect a difference in service times rendered compared to the applicable authorization on file, the schedule will be rejected. Providers must then make corrections to the schedule and submit the claim to reflect the corrected schedule.

Newly contracted Providers that are preparing staff and operational requirements to become compliant to the EVV Compliance program will be allowed a grace period. The grace period should be used to train staff on the system and ensure that the EVV Coordinators are aware of all performance visit maintenance tasks. The grace period is typically the first ninety days after receiving the Provider EVV data base. Any grace periods required must be approved by BlueCare.

Provider EVV Compliance Standards

- Provider agencies must adhere to all requirements included in the compliance plan.
- Providers are expected to import all member referrals within 24 hours of notification.
- Providers will receive authorizations and copies of the member's Person-Centered Support Plan (PCSP) indicative of services and service times. Upon receipt of the PCSP, providers are expected to complete the attestation process in the EVV database.
- Providers are expected to attach the assigned DSP to the member schedule within 24 hours of importing the new member.
- Providers must ensure all DSPs have been successfully trained on the GPS EVV tablet, EVV Telephony, and EVV Bring Your Own Device (BYOD). The DSP training record should be documented, including essential refresher and ongoing training when applicable (*including how to review schedules, and logging in and out*). Training records must include attestation by the DSP that is indicative of the employee's competency of EVV compliance and standards, including approved clock-in/out procedures.
- Providers are responsible for validating all DSPs are recording member visits (check in and check out) during the visit using the GPS tablet device, EVV Telephony, or EVV BYOD at all times. If the GPS tablet is not available, DSPs should use EVV Telephony or EVV BYOD as back-up methods.
- Adherence to completing all GPS tablet device assessments upon clocking out at the end of member visits or services is required.
- When a DSP identifies an issue with a GPS tablet device, the DSP must clock in using EVV Telephony or EVV BYOD and report the GPS issue to the provider immediately to prevent missed/late visits.
- When a DSP reports an issue with a GPS tablet device, the provider or responsible EVV Coordinator must contact BlueCare to report the issue within 24 hours of the visit to ensure interference with the quality of care provided to a member does not occur.
- Paper timesheets to document service delivery are only accepted with prior approval as the GPS Tablet Device, and EVV Telephony and EVV BYOD are the approved methods for clocking in and clocking out.
- Timely maintenance must be performed daily to clear exceptions; corrections must be completed within one week of the scheduled visit. Providers must ensure all visit maintenance is completed prior to submitting claims.
- Any scheduled visit that is identified as missed/late or changed must have populated an acceptable reason code within one day of the missed/late visit.
- When the reason code "Member refused service/Member refused Alternate Staff" is entered as a reason code, supporting comments identifying time, date, and person providing the information must be populated in the EVV data base. If the person providing the information is not the member, the comment must include the person's name and relationship to the member.
- Providers must receive prior approval from BlueCare when EVV visits require manual confirmation and need paper time sheets for invoicing.
- When time sheets are permissible, the following guidelines must be followed and include the following evidence prior to approval for releasing units. Providers may use their own timesheet template to include all standard agency information; and must contain an attestation statement certifying the accuracy of the data that will be submitted.
    - Timesheets should record two signatures; the DSP and member (or Member's authorized representative and their relationship to member).

- The signatures must be original; copied signatures will be rejected.
- The service and service date(s) must be accurately exhibited; timesheets submitted prior to service rendered dates will be rejected.
- Signatures must include the date that each signature was obtained.
- Any signature for which signature requirements are not met will be subject to advanced auditing, authentication, and possible Medicaid fraud referral.
- The reason(s) for paper timesheet submissions verses the approved, required use of the EVV system should be included to facilitate approval process.

Provider EVV Compliance Monitoring

The CONTRACTOR shall submit a monthly CHOICES and ECF CHOICES Provider Compliance Report for CHOICES Members regarding personal care, attendant care, and for ECF CHOICES Members regarding personal assistance and supportive home care. The report shall contain information on specified measures including but not limited to the following, Provider name and region in which services are provided, and the Provider ID.

BlueCare will monitor the compliance of each Provider and report on the following components of their required EVV usage and approved EVV methodology:

- Total number of visits and percentage of visits that were checked in and out via the GPS tablet;
- Total number of visits and percentage of visits that were checked in and out via the IVR system;
- Total number of visits and percentage of visits that were checked in and out via the worker's personal device;
- Total number of visits and percentages of visits that were checked in and out via manual confirmation process due to system or authorization issues:
- Total number of visits and percentage of visits that were checked in and out via manual confirmation process due to worker or Provider issues. For each of these visits, the report shall include specific and immediate actions taken to address the provider EVV compliance. Actions taken will include Provider's improvement toward meeting and maintaining compliance.

As part of the Provider compliance monitoring, BlueCare captures the frequency and usage of the GPS device as the first and preferred method of an individual provider staff person or worker when clocking in and clocking out when providing services to a member. The arrival and departure is also captured and monitored through the individual Provider staff person or worker's SSN. Monitoring continues and is reported in real time, or at a minimum, within twenty-four (24) hours when a worker has clocked into multiple visits at the same time. The overlapping information is shared among all MCOs when the worker works for multiple agencies and the person supported is not within the same MCO.

When a tablet is not available, or unable to be turned on, not receiving an internet signal, or if the tablet is broken, Providers are mandated and monitored to report these issues immediately.

Providers are allowed to use as the next approved method of clocking in and clocking out the Bring Your Own Device (BYOD). And lastly, the Interactive Voice Response (IVR).

Manual confirmation is not an electronic form of verification and is NOT COMPLIANT.

The EVV Tablet Exception Process

If a Provider reports that a worker has no available methods to electronically check in/out of the EVV system while providing service to a Member, BlueCare will do one or all of the following depending on the relevant situation:

- Refer Provider back to the EVV Compliance requirements and educate the Provider on all of the acceptable clock in/out methods.
- Determine the Member's ineligibility to receive a device as notated in the BlueCare system of record, and the reason why. Some Members do not have devices due to connectivity issues. Some Members do not have devices due to more than two (2) devices already being replaced due to reported loss or theft.
- Submit a "ping" request to determine if the Member actually has possession of the device. If this device is able to ping, then connectivity is available, and worker should be using device. An email will be sent with the outcome of the device's ping.

- Call Member to inquire about the device.
- Verify that the Provider's worker does not have or refuses to use their own smartphone for check ins/outs, therefore BYOD is not an option.

If BlueCare is able to validate that there are no available methods for electronic check ins/outs, we will notate the Member in our system of record and approve all requests for manual confirmations with corresponding timesheets. These approved exceptions will not be included when calculating Provider compliance.

Members on the exception list will be validated on a quarterly basis. If an electronic method of check in/out becomes available, then the Member will be removed from the list.

Oversight of Provider Compliance

BlueCare closely monitors and track the volume of manual confirmations, and when Providers are not compliant by meeting and maintaining 90% minimum performance on any reporting metrics. The below actions are taken against the non-compliant Provider or agency.

- Verbal and written warning/required and mandatory re-training (30 days)
- Corrective Action Plans (60 days)
- Suspension of New Referrals (90 days)
- Termination when the Provider is unable to demonstrate full compliance (120 days)

Providers receive monthly Individual Compliance Report indicative of their previous month's performance.

Any questions pertaining to the BlueCare Compliance Program should be directed to the CHOICESProviderRelations@bcbst.com .

O. Katie Beckett Part A Program

Katie Beckett Part A of Tennessee's Katie Beckett Part A Program ensures all individuals that qualify for the program to have full Medicaid Benefits, including benefits provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

Katie Beckett law eligibility for Part A:

- The child is under age 18
- The child has medical needs that result in severe functional limitations Based on criteria developed specifically for children
- The child's medical needs qualify for care in an institution (even though services will be provided at home)
- The cost of care cannot exceed the comparable cost of care for institutional care
- The child's medical needs are likely to last at least twelve months or result in death
- The child would qualify for supplemental security income (SSI)—except for parents' income and/or assets
- A Physician agrees that in-home care will meet the child's needs
- Child cannot be Medicaid eligible or receiving long-term services and supports in another Medicaid program

HCBS Providers that obtain executed contracts to support Katie Beckett individuals will provide wraparound Home and Community Based Services that consist of the following:

- Supportive Home Care and Respite
- Assistive Technology, Adaptive Equipment and Supplies
- Minor Home Modification
- Family to Family Support
- Community Integration Services
- Family Caregiver Education and Training
- Decision Making Supports
- Health Insurance Counseling and Forms assistance
- Vehicle Modification (through a third-party vendor)
- Community Transportation
- Community Support Development, Organization and Navigation

- Katie Beckett individuals may receive up to $15,000 a year in HCBS

Note: Electronic Visit Verification (EVV) will be required for Home Health agencies and HCBS Providers that support and provide in-home care to Katie Beckett individuals.

1915(c) Waiver Programs

A. 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 ID 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 Individuals 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 support 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. Also, DDA will be providing 3 regionally dispersed agencies that operate Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and are also Home and Community-Based Services (HCBS) provides the opportunity to consult with subject matter experts to develop transition plans for 3 ICF/IID locations. This initiative supports the MFP enrollments.

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 individuals with intellectual disabilities who are former individuals of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), former individuals 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 individuals 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 individuals 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 Individuals 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 support 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.

Entry to the CAC Waiver is available only to Tennessee residents in the target population who:

1. Meet Medicaid financial eligibility criteria in one of the specified eligibility groups; and
2. Need the level of care provided in an Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) level of care criteria, as evidenced by TennCare approval of a Pre-Admission Evaluation (PAE); and
3. Meet all applicable enrollment requirements set forth in TennCare Rule Chapter 1200-13-1-.28, including a determination by DDA that the individual's medical, behavioral and specialized services and support needs can be safely met through the Waiver, based on a pre-enrollment assessment; and a place of residence with an environment that is adequate to reasonably ensure the person's health, safety and welfare; and
4. Have been identified by the state as a person discharged from the Harold Jordan Center following a stay of at least 90 days.

Note: Former class individuals may no longer enroll in the CAC Waiver, unless all 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 Individuals 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 support 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.

B. Contact Information

TennCare and the Department of Disability and Aging (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 Documents (tn.gov)

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

- Dental Benefit Management Protocol
- Community Informed Choice for ICF/IID Admissions
- Employment Informed Choice Protocol
- Enabling Technology Protocol
- One System Reportable Events Management (REM) and Definitions
- Credentialing Standards Protocol
- Provider Recredentialing Protocol
- Dignity of Choice Protocol

For the 1915c Waiver providers, please email the Department of Disability and Aging (DDA) at DIDD_Business.Services@tn.gov for all claims related inquiries.

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

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

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

Individuals enrolled in the 1915(c) Waiver Program can call DDA's Member Services at: West TN Regional Office 1-866-372-5709; Middle TN Regional Office 1-800-654-4839; East TN Regional Office 1-888-531-9876 to speak to someone about their benefits. Individuals can also contact the 24-hour BlueCare Tennessee Nurse Help Line for around-the-clock clinical services and assistance with coordinating behavioral health care needs.

The following are additional BlueCare resources you may find helpful:

1. Contacts

- BlueCare of Tennessee website: https://bluecare.bcbst.com/
- Tennessee Department of Health: https://www.tn.gov/health

- Division of TennCare: https://www.tn.gov/tenncare/long-term-services-supports.html
- Contract Risk Agreement (CRA) for Managed Care Organizations: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf
- BlueCare Provider Manual: https://www.bcbst.com/providers/manuals/BCT_PAM.pdf
- Provider Registration for BlueCare access: http://www.Availity.com and click on "Register" in the upper right corner of the home page, select "Providers", click "Register", and follow the instructions in the Availity registration wizard.

2. Where to Turn for Help

Your Service Need	Operational Area	Contact
Eligibility Services, Claims, Inquiries	BlueCare Provider Services/Eligibility Service Line	1-800-468-9736
General Contracting Questions	Provider Network Services	1-800-924-7141, ext. 5775 (Provider Network Services)
Sandata/EVV Tech Support	Sandata Client Relations (EVV)	1-855-389-4843
Availity Claim Submission Tech Support	Availity	1-800-282-4548
CHOICES Web Portal Claims Tech Support	e-Business	(423) 535-5717, select option 2
Provider Education, General Provider Support, Assistance with Contracting/Credentialing	CHOICES/ECF/1915(c) Provider Relations	CHOICESProviderRelations@bcbst.com

C. Member Eligibility/Enrollment

Managed Long-Term Services and Supports I/DD Programs (MLTSS I/DD Programs) provide long-term services and supports for individuals with intellectual or developmental disabilities delivered through the managed care program, which includes the ECF CHOICES programs, the three 1915(c) HCBS waivers, and ICF/IID, and Katie Beckett services. TennCare determines enrollees that meet medical and financial eligibility to receive services and benefits under the TennCare program and then enrolls them in an MCO. However, all three 1915 (c) waiver programs are closed to new enrollment, with very limited exceptions.

Tennessee Family Support Program

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

1 T.C.A. §§ 33-5-203

"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."

The table below provides a description of criteria required for continued enrollment in a 1915 (c) Waiver or ICF/IID Based upon an intellectual disability.

	Developmental Disability (DD)	Intellectual Disability (ID)
Defined As	In a person over 5 years of age means a condition that is attributable to a mental or physical impairment or combination of mental and physical impairments, if manifested before 22 years of age is likely to continue indefinitely In a person up to 5 years of age means a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disability as defined for persons over 5 years of age if services and supports are not provided	Substantial limitations in functioning as shown by significantly sub-average intellectual functioning (IQ 70 or below) and adaptive skills
Manifested by Age	Before 22 years of age	Before 18 years of age
Amount of Skill Limitations	3 or more	2 or more
Common Diagnosis	▪ Cerebral Palsy ▪ Autism ▪ Hearing Loss ▪ Vision Impairment ▪ Fragile X Syndrome ▪ Fetal Alcohol Syndrome ▪ Intellectual Disability	Intellectual Disability ▪ Mild ▪ Moderate ▪ Severe ▪ Profound

Medical eligibility is determined by a Pre-admission Evaluation which is approved by TennCare and assigned a level of care. To be medically eligible to receive services in one of the 1915 (c) Waivers, level of care criteria for admission in an ICF/IID must be met in accordance with TennCare Rules. (http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm)

TennCare accepts applications and determines financial eligibility for enrollment. After a person is determined to be financially eligible for Medicaid long-term care services, TennCare then determines if the person is responsible for using some of his/her income to pay for the cost of care and establishes the amount he/she is responsible for paying (called “patient liability”). Federal law recognizes and allows for the use of the income of people supported (in Medicaid HCBS waivers) to maintain a residence in the community. Consequently, Centers for Medicare & Medicaid Services (CMS) also requires states to specify how much of a person’s available income can be set aside for living expenses and excluded from income when patient liability is established. Tennessee has specified that 300% of the Supplemental Security Income (SSI)/Federal Benefit Rate (FBR) will be set aside for personal expenses for the Comprehensive Aggregate Cap, Statewide, and Self-Determination Waivers.

In addition to income limits, there are also limits on the resources a person can have and still be eligible for Medicaid benefits. In general, people may not have more than $2000 in resources and maintain Medicaid eligibility. However, due to recent passage of the Able Act, a person who has more than $2000 in resources, may be financially eligible for Medicaid, if they abide by the requirements of the Able Act.

To continue to receive HCBS services an annual medical and financial redetermination is completed. The MCO will work with the Independent Support Coordinator, DDA Case Manager, ICF/IID or other HCBS provider, as applicable, to assure the annual reassessment which includes physical and behavioral health is completed for level of care eligibility and determination.

In addition, the MCO will work with the ISC, DDA CM, ICF/IID provider or member/representative payee to have all required financial redetermination forms completed and submitted to TennCare on an annual basis.

TennCare will determine if the member continues to meet eligibility to remain enrolled in I/DD MLTSS program and will send appropriate notification to the member.

The MCO's Population Health Program will coordinate with the ISC, DDA Case Manager, or ICF/IID provider, as applicable to place I/DD MLTSS members into appropriate programs and/or stratifications within a program. The programs and stratification will be determined according to risk level or other clinical or member-provided information as well as by the type of setting services that are delivered (i.e., nursing facility, ICF/IID, community Based residential alternative, or home-Based).

D. Member Benefits, Supports & Covered Services

Members receive the same benefits as all other BlueCare Members. Additionally, the following long-term services and supports are available to members who are enrolled in the 1915(c) waivers when the services have been identified as needed by the Independent Support Coordinator, Case Manager, as applicable and approved through submission of the Person-Centered Support Plan (PCSP).

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 member's institutional stay prior to being discharged and enrolled in the waiver)		X	X
Personal Assistance (PA) (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 (ET) (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 (SMESAT) (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 Discovery (limited to 1 unit per 1,095 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
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 Individualized Integrated Employment and Exploration for Self-Employment limited to 1 unit per 365 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	X	X	X

Benefit	Self-Determination	Statewide	CAC
days; Job Development Start-Up/Self-Employment Start-Up limited to 1 unit per 365 days)			
Community Participation (all employment/day services combined are limited to a maximum of 240 units per a 14-consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Facility-Based Day (may only be authorized for up to six (6) months at one time; all employment/day services combined are limited to a maximum of 240 units per a 14-consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Non-Residential Homebound Support (24 units per day; limited to a maximum of 10 days in a 14-day billing cycle and maximum of 243 days per person, per calendar year)	X	X	X
Individual Transportation (limited to maximum of 31 days/units per month)	X	X	X
Occupational Therapy (limited to 1 assessment with plan development per month; 3 assessments per year, per provider; 1.5 hours per day for services other than assessments)	X	X	X
Physical Therapy (limited to 1 assessment with plan development per month; 3 assessments per year, per provider; 1.5 hours per day for services other than assessments)	X	X	X
Speech, Language, and Hearing (limited to 1 assessment with plan development per month; 3 assessments per year, per provider; 1.5 hours per day for services other than assessments)	X	X	X
Behavior Services (limited to 8 hours per assessment for completion of the behavior assessment; 2 assessments per calendar year 6 hours per assessment for behavior plan development and staff training during the first 30 days following its approval; 2 assessments per year (5 hours for presentations at meetings per calendar year)	X	X	X
Orientation and Mobility Services (limited to 1 assessment with plan development per month; 3 assessments per year, per enrollee, per provider; and 52 hours of non-assessment services per calendar year)	X	X	X
Nutrition (limited to a maximum of six (6) visits per waiver participant, per calendar year of which no more than one (1) visit per waiver program year may be a Nutrition Services assessment; services other than the assessment (e.g., service recipient-specific training of caregivers; monitoring dietary compliance and food preparation) shall be further limited to a maximum of one visit per day)	X	X	X
Nursing (limited to a maximum of 48 units (12 hours) per day)	X	X	X
Adult Dental (limited to a maximum of $5,000 per calendar year and a maximum of $7,500 per 3 consecutive calendar years)	X	X	X
Respite (limited to a maximum of 30 days per calendar year)	X	X	X
Behavioral Respite (limited to a maximum of 60 days per calendar year)	X	X	X
Semi-Independent Living (limited to 1 unit per month (monthly), 31 days per month (regular daily), and 30 days per month (enhanced daily))	X	X	X
Supported Living (limited to 31 days/units per month; 14 days per year for out of state services)		X	X

Benefit	Self-Determination	Statewide	CAC
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

Note: In addition to the benefits specified above which shall be delivered in accordance with the definitions, including limitations set forth in the approved 1915(c) waiver and in TennCare rule, a person enrolled in a 1915(c) waiver program may receive short-term care (i.e., no more than 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 1915(c) waiver services will not occur within ninety (90) days from admission.

I. Service Definitions

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

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

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

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

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

a. Specialized behavioral safety interventions may only be used in the crisis section of a Behavioral Support Plan (BSP).
b. Devices used as mechanical restraint or protective equipment shall be commercially produced and in good repair.
c. BSPs involving the use of specialized behavioral safety interventions shall include clear descriptive criteria for the initiation and termination of the procedure in accord with the procedural definitions.
d. Specialized behavioral safety interventions shall require the initial and annual consent of the member or legal representative, if applicable, and approval of the Regional and Statewide BSCs prior to

implementation. Review by an HRC may be required. See DDA policy 90.1.3 Human Rights Review Process.

e. Behavior service providers may request a reporting variance from the DDA Coordinator of Behavioral and Mental Health Services when uses of specialized behavioral safety interventions are anticipated to exceed ten (10) uses per month. A form for these requests may be found at the DDA website, https://www.tn.gov/content/dam/tn/disability-and-aging/documents/about-us/divisions/clinical/behavior/Reporting_Variance_Request_Form_8_3_2015.pdf.

f. Because of these risks to the member and to comport with the HCBS Settings Final Rule the following person-centered practices and precautions shall be followed.
    1. The potential for use of restraints must be identified in the PCSP only if the member or legal representative, if applicable, consents. The potential use of restraints must be discussed by the COS.
    2. Restraints are only used to ensure the safety of the member and others.
    3. Restraints are only used as specified in the PCSP or for emergency circumstances and not as an ongoing intervention or treatment.
    4. All staff supporting the person must be trained in the use of restraints.
    5. The PCSP must indicate what positive interventions have been used prior to the use of restraint.
    6. The PCSP must indicate what has been tried before but did not work.
    7. The PCSP must indicate timelines for periodic reviews to determine if restraints are still necessary and plans must be reviewed on an individual basis.

g. General Precautions in the Use of Behavioral Safety Interventions. Restraints and protective equipment may be used only when necessary to protect the member or others from harm and when less-intrusive methods have been utilized and found to be ineffective in maintaining the safety of the member and others. The application of restraint or protective equipment must be implemented carefully to ensure protection from harm and to protect the rights of the member. Use of restraints and protective equipment carry the risk of psychological trauma, positional asphyxiation, restriction of circulation, and pressure on the muscular and skeletal system. Restraints and protective equipment may not be used excessively, for a time period beyond that which is necessary to ensure safety, as treatment or punishment, for staff convenience, or as a substitute for other services.

h. The physical condition of the person being restrained or protected shall be evaluated continuously throughout the restraint. People showing abnormalities of breathing, skin color, or other abnormalities shall be immediately released from restraint.

i. Restraint or Protective Equipment shall not be used when such use is contraindicated. Medical conditions which may contraindicate physical restraints are head or spinal injury, fracture, and pregnancy. Relative contraindications include: osteoporosis or history of fracture; asthma; seizures; heart disease, including hypertension; recent history of surgery; and a history of abuse.

j. The risks and benefits of restraint in response to these relative contraindications must be evaluated by the COS in consultation with the primary care physician to determine an appropriate course of action. The results of the individualized risk-benefits analysis shall be reported in the document that outlines the use of the restraint or protective equipment.

1. <u>Prohibited Procedures</u>:

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

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

- **Noxious or painful stimuli.** Events that a member may describe as unpleasant to the senses or that result in tissue damage or lasting impairment.

2. Therapeutic and therapy related services

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

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

Descriptions of services are available online at

https://www.tn.gov/disability-and-aging/provider-information/service-definitions.html

3. Nursing and Dental Services

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

Nursing Services

Waiver Definition for Nursing Services

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

Nursing Assessments

Nursing assessment is not a separate billable service.

Planning Nursing Services

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

Obtaining Approval for Nursing Services

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

- The PCSP must be submitted with a physician's order.
- The PCSP must provide documentation of a chronic medical condition requiring the provision of nursing services.
- The PCSP must provide documentation to justify that the nursing service is medically necessary to ensure the health and safety of the member or to avoid a more costly and restrictive service.

- The PCSP must include a statement that nursing services are not available or were denied through Medicare, the TennCare Managed Care Organization ("MCO") program or private health insurance.

Self-Assessment and Internal Quality Improvement ("QI")

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

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

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

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

Provision of Nursing Services

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

Documentation of Nursing Services

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

Reimbursement Considerations

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

- Services provided without a physician's order.
- Services provided prior to authorization and approval.
- Services provided that do not require the expertise of a skilled nurse and could be safely performed by direct support staff.

- Assessment activities not considered a component of the direct nursing service being provided (e.g., If changing a wound dressing, assessment of the wound is a part of the physician ordered nursing activity; however, doing a comprehensive head to toe assessment would not be related.).
- Services provided to a member in a nursing facility or ICF/IID or within a program operated by a local school system.
- Time spent waiting for a member to arrive at a particular location.
- Time spent traveling between service sites to locate the member.
- Units of service billed, but not supported by required documentation.
- Visits made for purposes other than the provision of direct, hands-on nursing services (e.g., to perform staff supervisory activities).
- Time spent performing administrative activities, such as documentation, attending meetings, etc.

Dental Services

All dental services are provided to Members through one statewide Dental Benefit Manager (DBM). Services are provided as Medically Necessary to treat the oral health needs of these Members. If you need additional information, please call DentaQuest Customer Service at 1-800-294-9650.

Note: ECF or 1915(c) members will continue to receive the supplemental covered dental benefits for waiver members through the existing ECF CHOICES and 1915(c) waiver dental processes.

Adult dental benefits are not applicable to members who have CoverKids. CoverKids children have dental benefits through age 18.

4. Respite, Personal Assistance, and Individual Transportation Services

Respite Services

Waiver Definition of Respite Services

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

Additional Requirements Applicable to Respite Services:

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

Personal Assistance ("PA") Services

Waiver Definition for Personal Assistance ("PA") Services

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

Licensure Requirements

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

II. Employment Services

1. Supported Employment—Individual

Job Coaching

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

Stabilization and Monitoring

Once the support needs of a person are one (1) hour per week or less, Job Coaching through monthly Stabilization and Monitoring will be authorized. This requires a minimum of one (1) monthly face-to-face contact with the member, one (1) monthly contact with the employer (not applicable for self-employment), and the ability of the provider to respond to prevent job loss and/or pursue a change in service authorization, as needed. Transportation during the provision of these services is included in the rates paid for these services. Transportation of a participant to and from these services is included in the rates paid for these services when such transportation is needed by a participant.

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

Benefits Counseling

Benefits Counseling provides work incentives counseling and planning services to persons actively considering or seeking IIE or SE, or career advancement in either of these types of employment. This service is provided by a certified Community Work Incentives Coordinator (CWIC) or certified Work Incentive Practitioner (WIP-C). In addition to ensuring this service is not otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), the waiver may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual. Benefits Counseling must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation/interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device. These services are designed to support the achievement of IIE and SE outcomes consistent with the individual's personal and career goals, as determined through Exploration, Discovery and/or other similar career planning processes and which include an introduction to the variety of work incentives available to individuals receiving Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI), Medicaid and/or Medicare.

Job Development (includes Job Development Plan, Self-Employment Plan, Job Development Start-up, and Self-Employment Start-Up)

Job Development (JD) Plan or Self Employment (SE) Plan is a time-limited and targeted service designed to create a clear and detailed plan for JD or for the start-up phase of SE. This service is limited to thirty (30) calendar days from the date of service initiation for JD Plan and is limited to ninety (90) calendar days from the date of service initiation for SE Plan. This service includes a planning meeting involving the individual and other key people who will be instrumental in supporting the individual to become employed in individualized integrated employment (IIE) or SE as defined in TennCare Rule. This service culminates in a written plan, using a template prescribed by DDA that incorporates the results of Exploration and/or Discovery, if previously authorized. The written plan is due no later than thirty (30) calendar days after the service commences. For SE goals, this service results in the development of a SE business plan, including potential sources of business financing (such as VR, Small Business Administration loans, PASS plans), given that Medicaid funds may not be used to defray the capital expenses associated with starting a business. This service is paid on an outcome basis, after the written plan is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

Job Development (JD) Start-Up or Self Employment (SE) Start-up is a time-limited service designed to implement a JD or SE Plan as follows: o JD Start-Up is support to obtain an individualized competitive or customized job in an integrated employment setting in the general workforce, for which an individual is compensated at or above the minimum wage, but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The JD strategy should reflect best practices and adjusted based on whether the individual is seeking competitive or customized employment.

SE Start-Up is support in implementing a SE business plan. The outcome of this service is expected to be the achievement of an IIE or SE outcome consistent with the individual's personal and career goals, as determined through Exploration and/or Discovery if authorized, and as identified in the JD or SE Plan that guides the delivery of this service.

These services are designed to support the achievement of IIE and SE outcomes consistent with the individual's personal and career goals, as determined through Exploration, Discovery and/or other similar career planning processes and which include an introduction to the variety of work incentives available to individuals receiving Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI), Medicaid and/or Medicare.

Exploration and Self-Employment Exploration

This is a time-limited and targeted service designed to help a person make an informed choice about whether s/he wishes to pursue IIE or SE. This service is not appropriate for people who already know they want to pursue IIE or SE. This service includes career exploration activities to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to IIE or SE This service also includes exploration of IIE or SE opportunities in the local area that are specifically related to the person's identified interests, experiences and/or skills through four to five uniquely arranged business tours, informational interviews and/or job shadows. Each business tour, informational interview and/or job shadow shall include debriefing with the person after each opportunity. This service also includes introductory education on work incentives for individuals receiving publicly funded benefits (e.g. SSI, SSDI, Medicaid, Medicare, etc.), and includes introductory education on how Supported Employment services work (including VR services). Educational information is provided to the person and the legal guardian/conservator and/or most involved family member(s), if applicable, to ensure legal guardian/conservator and/or family support for the person's choice to pursue IIE or SE. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the person and the legal guardian/conservator and/or most involved family member(s), if applicable. The Exploration service shall be completed no more than sixty (60) calendar days from the date of service initiation, unless extenuating circumstances warrant an extension. Exploration service is expected to involve, on average, forty (40) hours of service.

Self-Employment Exploration includes but is not limited to: Initial meeting with job coach or job developer to discuss SE goals, collecting information to assist the person in making an informed choice on the pursuit of SE, and feasibility study and consultation with local advisory agencies. This may consist of virtual or in-person meetings with job developer and advisory agencies with the goal of informing the person on SE. At the conclusion of SE Exploration, the individual will choose whether to continue

pursuing SE. Additionally, the job developer will work to identify supports needed, discuss fading of paid job supports, and the expectations of job developer and job seeker. Completion and approval of the SE Exploration template is required for completion. Benefits counseling is mandatory during this phase through VR or the waiver.

Individual Discovery

This is a one-time, time-limited, and targeted service for an individual who wishes to pursue IIE or SE but for whom more information is needed to determine the following prior to pursuing IIE or SE: o Strongest interests toward one or more specific aspects of the labor market; o Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through SE; o Conditions necessary for successful employment or SE. Discovery involves a comprehensive analysis of the person in relation to the three bullets above. Activities include observation of person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, identification of the person's strong interests and existing strengths and skills that are transferable to IIE or SE, Discovery also involves identification of conditions for success based on experience shared by the person and others who know the person well, and observation of the person during the Discovery process. Discovery results in the production of a detailed written Profile, using a standard template prescribed by DDA, which summarizes the process, learning and recommendations to inform identification of the person's IIE or SE goal(s) and strategies to be used in securing this employment or SE for the person. If Discovery is paid for through the Waiver, the person should be assisted to apply to VR for services to obtain IIE or SE. The Discovery Profile should be shared with VR staff to facilitate the expeditious development of an Individual Plan for Employment (IPE). Discovery shall be limited to no more than ninety (90) calendar days from the date of service initiation unless extenuating circumstances warrant an extension.

Supported Employment—Small Group Employment Support

This service provides Employment services and training activities to support successful transition to individualized competitive, integrated employment or self-employment, or to supplement such employment when it is only part-time. Group size will not exceed three (3) people supported. Reimbursement depends on size of group during service. Supports include career planning and exploration activities, discovery classes/activities, and/or paid work on mobile work crews or work enclaves in integrated settings. People supported must be paid in accordance with all applicable federal and state labor laws, with the optimal expectation being wages that are at or above the state minimum wage. The PCSP must include what efforts are being made to transition the member to individualized competitive, integrated employment or self-employment and any barriers encountered. Any member using this service to supplement part-time individualized competitive, integrated employment must be offered assistance to increase his/her work hours as an alternative or partial alternative to this service.

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

A one-time transition payment is available to providers that have successfully supported a member to transition from Small Group Employment to Individualized Integrated Employment or Self-Employment.

Quality Incentive Payments

There are two (2) quality incentive payments available which can be earned by a provider up to two (2) times per year. A provider is eligible for the base fee payment of $1500 when the member has been employed between 15-19 hours per week in competitive, integrated employment during the previous six-month calendar period (between 390 and 519 hours total). The top tier of $2000 per member is available for people supported who worked twenty (20) or more hours per week during the previous six-month calendar period (at least 520 hours total). Providers will submit payment requests using the invoicing form provided by DDA to the applicable Regional Office administrative unit and must also supply verification of hours worked in the form of pay stubs for reimbursement to occur. Incentive payments for

hours worked do not count against the annual member expense cap of people supported in the Statewide or Self-Determination Waivers.

Utilizing Natural Supports in the Provision of Day Services

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

Requirements and Limitations of Natural Supports

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

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

2. Day Services and Other Service Options

Introduction to Day Services

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

General Requirements for Day Services

Providers of Day services are required to abide by the requirements specified in the waiver service definitions[1], this MLTSS provider manual, the provider agreement, TennCare protocols, and other applicable DDA policies and procedures.

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

Vocational exploration and discovery-focused vocational assessments may be performed whenever needed and are required at least every three (3) years, unless the member or legal representative (as applicable) has explored what integrated employment is and has decided that s/he does not wish to seek employment and declines to sign a consent for the assessment. [2] For those people supported who choose other service options, the minimum DDA requirement is that the option of integrated employment

be reconsidered during the Circle of Support ("COS") meeting and documented during each annual PCSP update.

Providers of Day services are responsible for Personal Assistance ("PA") needs during the provision of Day services, but PA services cannot be billed separately during the same time period the Day service is billed.

A PCSP of a member may include more than one (1) approved service (e.g. Supported Employment, Community Participation, Intermittent Employment and Community Integration Wrap-around Supports, Facility-Based Day Supports, etc.), but more than one (1) service may not be billed during the same 15-minute unit of time.

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

Day Service Settings

Day services are required to occur in the most integrated, least-restrictive setting possible, as appropriate to the member. Providers are responsible for ensuring that Day services are provided in settings that comport with the Centers for Medicare & Medicaid Services ("CMS") Home and Community Based Services ("HCBS") Settings Final Rule. CMS guidance regarding the settings in which Day services are provided is available online.[3] Providers are required to familiarize themselves with the requirements of the Final Rule. The HCBS Settings Final Rule requires that the setting:

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

Types of Day Services

- Community Participation Supports
- Intermittent Employment and Community Integration Wrap-Around Supports
- Facility Based Day Supports
- Non-Residential Homebound Support Services
- Residential Special Needs Adjustment—Homebound

Community Participation Supports

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

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

- Exploring volunteer opportunities or volunteering in the community
- Being an active member of the community (examples are being a member of a garden club, neighborhood organization, local gym, etc.)
- Taking a class in the community to learn a new skill
- Participating in age-appropriate experiences that match the interests of the member
- Developing age-appropriate hobbies that match the interests of the member
- Training in a specific skill the member wants to learn
- Using community resources, such as public transportation

- Participating in opportunities focused on training and education for self-determination and self-advocacy
- Maintaining existing and developing new relationships with individuals of the broader community (e.g. neighbors, co-workers and other people who do not have disabilities and are not paid or unpaid caregivers)
- Participating in activities that promote health and wellness

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

Intermittent Employment and Community Integration Wrap-Around Supports

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

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

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

Facility-Based Day Supports

Facility-Based Day supports may be provided in a facility setting only when selected by a member who needs time-limited pre-vocational training when such training is not available on the job site. Facility-Based Day supports may also be provided to people supported who choose through the person-centered support planning process to participate in a Facility-Based program in order to focus on the development of individualized and specific skills that will support them in pursuing and achieving community living goals. Facility-Based Day-supports must allow for opportunities for all people supported to be engaged in the broader community when appropriate and be specified in the PCSP. Opportunities to transition into more integrated settings, including competitive, integrated employment, must be evaluated at least every six (6) months. Providers should refer to the joint TennCare and DDA memos issued on July 16, 2015, and June 20, 2016, regarding appropriate billing of Facility-Based Day supports .[4] It should be noted that the joint memos referenced above are consistent with CMS guidance issued in 2011.[5]

Homebound Support Services

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

The Non-Residential Homebound Support Service and the Residential Special Needs Adjustment-Homebound Support services may be authorized only when a member meets the definition of "homebound" and is unable (not unwilling) to participate in Employment or Day services and needs to remain at his/her residence for the full twenty-four-hour day, except for leaving the home for medical treatment and/or medical appointments. 'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14-day billing period.

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

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

Employment & Day Services (tn.gov)

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

Short Term Stay

In addition to the benefits specified above which will be delivered in accordance with the definitions, including limitations set forth in the approved 1915(c) waiver and in TennCare rule, a member enrolled in a 1915(c) waiver program, may subject to requirements in 2.9.7.3.27.11 receive short-term care (i.e., no more than ninety (90) days) in a nursing facility 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.

BlueCare Tennessee will review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for 1915(c) waiver individuals only when (1) the member is enrolled in a 1915(c) waiver program, and receiving HCBS upon admission; (2) the member meets the applicable institutional level of care in place at the time of admission (i.e., NF level of care for a short-term NF stay. (3) the Individual'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. BlueCare Tennessee 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 BlueCare Tennessee is not notified until after the admission occurred.

Within fifteen (15) days of admission (or knowledge of the admission if BlueCare Tennessee is not notified until after the admission occurred), BlueCare Tennessee shall work with the member (and his/her 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. If the member (or his/her health care representative) is unwilling to engage in transition planning, BlueCare Tennessee shall continue to engage the member on each subsequent visit. BlueCare Tennessee 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.

The ninety (90) day limits 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, BlueCare Tennessee 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.

BlueCare Tennessee shall monitor, on an ongoing basis, individuals 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 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, the BlueCare Tennessee shall include explanation regarding why the benefit limit has been exceeded, and specific actions BlueCare Tennessee is taking to facilitate discharge to the community including the anticipated timeline.

III. Person-Centered Support Plan (PCSP)

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

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

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

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

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

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

Identify a specific and individualized assessed need.

Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

1. Document less intrusive methods of meeting the need that have been tried but did not work.
2. Include a clear description of the condition that is directly proportionate to the specific assessed need.
3. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
4. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
5. Include informed consent of the member.
6. 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 support plan, and the member must provide informed consent for the restriction."[3]

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

The person-centered support 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 support planning process:

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

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

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

The Circle of Support (COS)

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

[3] http://www.nasddds.org/news/cms-issues-non-residential-guidance/

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

Authorizations for Services in the PCSP

Providers will be approved to provide services to individuals 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.

IV. Independent Support Coordination and DDA Case Management

Independent Support Coordinators (ISCs) will facilitate 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), 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 support planning for services delivered under Section 1915(c) of the Social Security Act.

Support Coordination provider agencies will:

1. Ensure that all person employed to render support coordination services (Independent Support Coordinators or ISCs) receive effective guidance, mentoring, and training, including all training required by TENNCARE and 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.
2. Provide Support Coordination services in a manner consistent with the 1915(c) waiver, TennCare rules, policies, protocols, and this Contract.
3. Provide Support Coordination services in a manner that ensures person-centered support 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 support planning for services delivered under Section 1915(c) of the Social Security Act.
4. Initiate and oversee at least annual reassessment of the Individual's level of care eligibility, including initial and at least annual assessment of the Individual'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 Individual's specific assessed need and set forth in the PCSP.
5. Support the Individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
6. Implement the Employment Informed Choice (EIC) process for individuals 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.

7. Coordinate with BlueCare Tennessee 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.
8. 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 Individual'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 Case Manager for SD waiver individuals) shall include, but are not limited to:

- General education about the waiver program and services, including member rights and responsibilities; providing necessary information and support to the member to support his/her direction of the person-centered support planning process to the maximum extent desired and possible
- Initial and ongoing assessment of the Individual's strengths, needs and preferences, including an understanding of what is important to and important for the member and the development of a PCSP that effectively communicates that information to those providing supports
- Identification and articulation in the PCSP of the person's individualized goals related to work, personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness, and actions necessary to support the person in achieving those outcomes
- Leveraging member strengths, resources and opportunities available in the person's community, and natural supports available to the person or that can be developed in coordination with paid waiver services and other services and supports to implement identified action steps and enable the person to achieve his/her desired lifestyle and individualized goals for employment, personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and self-determination, and personal health and wellness;
- Initial and ongoing assessment of how Enabling Technology could be used to support the person's achievement of individualized goals and outcomes and planning and facilitation of Enabling Technology supports, as appropriate to include, completion of an Enabling Technology Screening form and an Enabling Technology Plan when enabling technology is being used;
- Facilitating an employment informed choice process with the expectation of exploring employment and supporting the person to make informed choices about work and other integrated service options.
- Actual development, implementation, monitoring, ongoing evaluation, and updates to the PCSP as needed or upon request of the member
- Additional tasks and responsibilities related to consumer direction of services eligible for consumer direction, as prescribed by TENNCARE
- Coordination with the Individual's MCO (applicable for ISCs and DDA Case Managers) and physical and behavioral health care providers and HCBS providers to improve and maintain health, support personal health and wellness goals, manage chronic conditions, and ensure timely access to and receipt of needed physical and behavioral health services
- Supporting the Individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be

integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid 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 individuals 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

Every person has the right to make Advance Medical Directives in accordance with Tennessee and Federal law.

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.

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 individuals served.

BlueCare Tennessee shall require that all 1915(c) waiver Independent Support Coordination providers participate in education and training activities as required by BlueCare Tennessee to understand physical and behavioral health benefits, and collaborate with BlueCare Tennessee 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. BlueCare Tennessee will also require all ISCs supporting individuals 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 individual caseloads within the maximums and under the conditions established below, as needed to meet the needs of the people supported on those caseloads.

Maximum Caseloads for Independent Support Coordinators (ISC):

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

Exceeding Maximum Caseloads:

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

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

V. DDA Case Manager

A qualified individual employed by DDA who provides support coordination services to individuals in the Self-Determination Waiver and is responsible for, the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals 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.

VI. Consumer Direction

Consumer direction (also referred to as self-direction) is a process by which eligible 1915(c) waiver HCBS are delivered; it is not a service. If a member chooses not to direct his/her care, he/she shall receive authorized 1915(c) waiver HCBS through contract providers. While the denial of an Individual's request to participate in consumer direction or the termination of an Individual's participation in consumer direction gives rise to due process including the right to fair hearing, such appeals shall be processed by the TennCare Division of Long Term Services and Supports rather than the TennCare Solutions Unit, which manages medical appeals pertaining to TennCare benefits (i.e., services).

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

Independent Support Coordinators and DDA Case Managers will offer 1915(c) Waiver individuals, 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 individuals the opportunity to have choice and control over how eligible 1915(c) waiver HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TennCare.

For 1915(c) waiver individuals, BlueCare Tennessee with TennCare will develop a Consumer Direction protocol that provides detailed guidance regarding the Independent Support Coordinator's (ISC) and DDA Case Manager's responsibilities pertaining to Consumer Direction.

The FEA is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers, or anyone acting for or on behalf of the CONTRACTOR conducts criminal background checks and registry checks in accordance with state law and TennCare policy. At a minimum, registry checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry and National Sexual Offender Registry, Social Security Death Master File, and List of Excluded Individuals/Entities (LEIE). The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers. Criminal background checks and registry checks must be performed on any employee or volunteer who will have direct contact with a member in CHOICES, ECF CHOICES, or 1915(c) waivers. Any employee or volunteer supporting CHOICES, ECF CHOICES, or 1915(c) waiver members who will not have direct contact with these members must have required registry checks completed prior to beginning this support. Unless federal or state laws prohibit individuals with certain criminal records from holding positions or engaging in certain occupations, an individual whose background check reveals past criminal conduct shall be given an opportunity to undergo an individualized assessment in accordance with the applicable laws and legal guidance.

The Consumer Direction Protocol will be located on TennCare's LTSS Protocol webpage upon CMS approval.

VII. 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 the 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.[4] 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 individual to discrimination on the ground of race, color, or national origin in its employment practices under such program, e.g., recruitment, layoff or termination, or rates of pay.
10. Denying a member, the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

VIII. Self-Direction of Health Care Tasks

The Member or his/her Representative will identify one or more Workers who will perform health care tasks during delivery of eligible 1915(c) services. If a Worker agrees to perform the health care tasks, the tasks to be performed must be specified in the Service Agreement. The member or his/her Representative for CD is solely responsible for identifying a worker who is willing to perform health care tasks, and for instructing the paid personal aide on the task(s) to be performed.

The Member or his/her Representative must also identify in the back-up plan who will perform the health care task if the worker is unavailable or stops performing the task for any reason.

[4] The Universal Declaration of Human Rights: udhr.pdf (un.org)

Self-direction of health care tasks for 1915(c) waivers is a decision by a 1915(c)-waiver member to direct and supervise a person paid to deliver 1915(c) waiver HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a 1915(c)-waiver member may elect to have performed as part of the delivery of eligible 1915(c) waiver HCBS the member is authorized to receive.

The individual or caregiver who chooses to self-direct a health care task is responsible for initiating self-direction by informing the health care professional who has ordered the treatment that involves the health care task of the individual or caregiver's intent to perform that task through self-direction. When a licensed health care provider orders treatment involving a health care task to be performed through self-directed care, the responsibility to ascertain that the patient or caregiver understands the service and will be able to follow through on the self-directed care task is the same as it would be for a member or caregiver who performs the health care task for the member or caregiver's own self, and the licensed health care provider incurs no additional liability when ordering a health care task that is to be performed through self-directed care. The role of the caregiver or Direct Support Professional (DSP) in self-directed care is limited to the physical aspect of health.

A 1915(c) member shall not receive additional amounts of any service because of his decision to self-direct health care tasks. Rather, the health care tasks shall be performed by the worker while delivering eligible 1915(c) already determined to be needed, as specified in the PCSP.

Ongoing monitoring of the worker performing self-directed health care tasks is the responsibility of the member or his/her Representative. Members are encouraged to use a home medication log as a tool to document medication administration. Medications should be kept in original containers, with labels intact and legible.

(Self-direction of Health Care Tasks will be effective (upon CMS approval of amendment/renewals))

E. Provider Requirements

All providers must ensure that people supported 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 people supported 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 people supported are informed of who the Title VI Local Coordinator is and how to contact him/her.
4. All providers must develop and implement written policies and procedures addressing:
    a. Employee training to ensure Title VI compliance during service provision.
    b. Employee training to ensure recognition of and appropriate response to Title VI violations.
    c. Complaint procedures and appeal rights pertaining to alleged Title VI violations for persons supported.
    d. Personnel practices governing responses to employees who do not maintain Title VI compliance in interacting with people supported.
5. All providers must provide or arrange language assistance (i.e., interpreters and/or language-appropriate written materials) to people with LEP at no cost to the person.
6. All providers must provide meaningful access to services to people with LEP.
7. All providers must have a mechanism for advising people supported regarding the options for filing a Title VI complaint.
8. All providers must display Title VI materials in conspicuous places accessible to people supported. Materials are available from Local Coordinators, DDA Regional Office Title VI Coordinators, or the 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.
14. Ensure that your agency has the capability to ensure physical access, reasonable accommodations, and accessible equipment for furnishing of services to individuals supported with physical or mental illness.

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. People supported through the DDA Waivers shall be entitled to the following rights including, but not limited to:

- Being treated with respect and dignity as a human being.
- 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).
- Due process under federal and state law.
- 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").
- Receiving information and providing informed consent regarding proposed services and other treatments, rights restrictions, psychotropic medication, and restricted BSPs
- Receiving services and supports, regardless of gender, race, creed, marital status, national origin, disability, sexual orientation, ethnicity, or age.
- Being free from abuse, neglect, and exploitation.
- Receiving appropriate, quality services and supports in accordance with their PCSPs and to driving their own person-centered support planning processes.
- Receiving services and supports in the most integrated and least-restrictive community settings that are appropriate, Based on the needs of the member.
- Having access to and support in understanding DDA rules, policies, and procedures pertaining to services and supports.
- Having access to and support in understanding personal records and to have services, supports, and personal records explained so that they are easily understood.
- Having personal records maintained confidentially.
- Owning and having control over personal property, including personal funds.
- Having access to and support in understanding information and records pertaining to expenditures of funds for services provided.
- Having choices and making decisions.
- 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.
- Having privacy and being free from unauthorized intrusion and unwanted observation.
- 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.

- Being able to associate publicly or privately with friends, family, and others.
- Having intimate relationships with other people of one's own choosing.
- Practicing the religion or faith of one's choosing.
- Being free from coercion and the inappropriate use of physical or chemical restraint.
- Having access to transportation and community settings used by the general public.
- Being fairly compensated for employment.
- 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 individuals to support people to exercise their rights, be accountable for their personal responsibilities, and make decisions. When supporting adults, consider the strategies listed below to help people make decisions that require informed consent.

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

Death Reporting and Death Reviews

Entities serving individuals in the HCBS waiver or in a state operated ICF/IID or developmental center will comply with the death reporting protocol once finalized which will replace the DDA policy.

Death Reporting and Review Policy

Provider should refer to the Death Review Protocol for compliance, once the protocol has been completed and uploaded to the TennCare website.

Autopsies

The Department encourages family individuals and or legal representatives of people supported 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.

1. Provider Agreements

All provider agreement requirements are outlined within the Contractor Risk Agreement, which can be found on TennCare's website. Additionally, providers that support members with personal emergency

service, pest control or enabling technology are required to meet all specified requirement within executed provider agreements. PERS providers are not required to provide emergency services or render services without the requirement of prior authorization of any kind specific to prenatal services, CLIA, hospital protocols, reimbursement for obstetric care, pharmacy, or PBM. Providers of PERS services must carry adequate liability and other appropriate forms of insurance coverage that must be reasonable and approved by the credentialing MCO. Providers of assistive technology and enabling technology must carry adequate liability and other appropriate forms of insurance coverage that must be reasonable and approved by the credentialing MCO.

https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf

No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section A.2.3.5 of the contract risk agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with BlueCare or in the employment practices of the provider. The provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.

Religious and Ethical Directives - For a Provider Agreement that includes Ethical and Religious Directives, or when a provider has conscience and religious beliefs that prevents them from providing certain TennCare covered services due to those beliefs, include the following requirements:

The Provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives or its conscience and religious beliefs to the contractor. The CONTRACTOR shall furnish this list to TENNCARE, notating those services that are TennCare covered services. This list shall be used by the CONTRACTOR and TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives or its conscience and religious beliefs.

The provider shall be interacting 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, therefore, the provider shall have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures, and for regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equity and eliminate bias with generating assessment results. The provider's staff members carrying out the terms of the provider agreement shall 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. The provider entity's new hires carrying out the terms of the provider agreement shall receive this training within thirty (30) days of joining the entity's workforce.

The provider 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. The provider agrees 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 the provider 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 BlueCare if the member needs assistance with filing a complaint.

Electronic and Information Technology Accessibility Requirements. To the extent that the provider is using electronic and information technology to fulfill its obligations under this Contract, the provider agrees 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, the provider 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/).

2. Provider Roles and Responsibilities

All providers that require licensure must obtain the appropriate license prior to contracting with the MCO. It is required that providers maintain licensure for services offered at all times while services are being rendered to 1915 (c) members. Providers that have allowed licensure to lapse will not be reimbursed for services provided during the lapsed period. Providers will be required to show proof of current licensure during 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 the DDA website, https://www.tn.gov/DIDD/divisions/office-of-licensure.html.

Personnel Policies are required if staff are employed by a provider. Personnel policies are not required of independent providers or when services are provided only by subcontractor's staff in accordance with an MCO 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 people supported 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 people supported, 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 people supported.
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 under the Health Services: https://www.tn.gov/disability-and-aging/provider-information/guidance-and-policy.html.
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 people supported. As a condition of the person's voluntary employment, a signed consent release shall be obtained at the time of hiring. The release shall be in effect the duration of his/her employment.

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

- Be at least eighteen (18) years of age if supporting people in employment services.
- Staff who have direct contact with or direct responsibility for people supported must be able to effectively read, write, and communicate verbally in English and read and understand instructions, perform record-keeping duties and write reports.
- 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.
- Staff who will have direct contact with or direct responsibility for people supported 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 people supported must not be listed on the Tennessee Abuse Registry, the National Sexual Offender Registry, the Tennessee Felony Offender Information List (FOIL), and the Office of Inspector General's List of Excluded Individuals/Entities (LEIE).

Family individuals 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.

In the event that a provider agency wishes to employ, retain, hire, or contract with an individual as staff or volunteer who would have direct contact with or direct responsibility for people supported and who has been found to have a prior conviction, as outlined in the current provider agreement, the provider must request an exemption for the individual as noted in the credentialing protocol.

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

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

Primary Provider Responsibilities for Hospitalizations

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

3. Background Checks

Providers are required to complete **statewide** criminal background checks, including registry checks, and exclusion checks. At a minimum, registry checks shall include a check of the Tennessee Abuse Registry, and National Sexual Offender Registry and List of Excluded Individuals/Entities (LEIE), and TennCare's Terminated Provider List, Social Security Death Master File, SAM, Criminal background checks and

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

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

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

Additional DDA Requirements Pertaining to Background Checks

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

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

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

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

Reimbursement for Criminal Background Checks

Reimbursement for criminal background checks will be made as follows:

1. The provider requesting the background check will pay the TBI, the FBI, or the Tennessee-licensed private investigation company.
2. DDA will reimburse the provider for the cost of the criminal background check if the following conditions are met:
    a. The provider is properly licensed and has a current Provider Agreement.
    b. The background checks have been completed by the TBI, FBI, or a Tennessee-licensed private investigation company.
    c. Funding is available for DDA to make such reimbursement payments.

4. Required Training and Staff Development for Direct Support Professional for ECF and Waiver staff

Please refer to the current training requirements located on the DDA website as noted below:

https://www.dropbox.com/scl/fi/difqgvsnoxvt0vxhny0g4/Employment-Staff-Training-Requirements-for-All-HCBS-Programs.pdf?rlkey=6aqgs56jryq1zbklqqpxd78d2&dl=0

Training Resources

Staff development opportunities are offered utilizing web-Based learning and classroom instruction. Employer mentoring and support ensure a workforce with the basic competencies to support people with intellectual disabilities in achieving life goals Based on what is important to them within the context of what is important for them. To complement this chapter and provide additional resources, refer to the training requirements on the Department's website, https://www.tn.gov/content/dam/tn/DIDD/documents/divisions/training/requirements/Training-Req-for-Provider-Staff-Categories.pdf . This plan includes course and documentation requirements for web-Based vendors, as well as other courses provided by DDA.

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 the 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.

Frequency of certification verification

- Certification shall be verified annually.

Enabling Technology

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

Specific courses and timelines for completion are identified and outlined in the Enabling Technology Training Requirements for Staff Categories document available on the DDA website, Training-Req-for-Provider-Staff-Categories.pdf (dropbox.com) 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 the DDA electronic learning management (ELM) system.

Provider staff following the Enabling Technology training requirements must also complete all required trainings as outlined by the DDA *Training Requirements for Provider Staff Categories* available on the 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 Protocol can be found on TennCare' s webpage.

Remote Staff

Remote Support Staff are staff that do not provide direct, hands-on supports and assistance to the people supported by the agency but do provide indirect supports and services to people supported 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.

5. 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 Disability and Aging Chapter 0465-01-03 Administration of Medication by Unlicensed Personnel: https://www.tn.gov/content/dam/tn/disability-and-aging/documents/about-us/divisions/clinical/nursing/med-admin/Medication%20Administration.pdfProviders shall ensure that all unlicensed staff who administer medication have successfully completed the 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 the 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 his/her clinical judgement and standard of care.
- A separate Medication Administration Record (MAR) must be maintained for each person receiving medications. MAR required elements are specified in the 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 person supported does not consent or refuses the PRN psychotropic medication when administration is attempted.
- Medication variances and omissions can occur during transcribing, preparing, administering, or in the documentation of a medication. A medication variance occurs at any time that a medication is given in a way that is inconsistent with how it was ordered by the prescribing practitioner and in accordance with the "Eight Rights" (i.e., right dose, right drug, right route, right time, right position, right texture, right person, and right documentation).

Administration and Supervision of Psychotropic Medications

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

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

Monitoring for Psychotropic Medication Side Effects and Involuntary Movement

It is the responsibility of the practitioner/prescriber of psychotropic medications to ensure that screening for Tardive Dyskinesia ("TD") or medication-induced involuntary movement disorders and monitoring for extrapyramidal side effects is conducted periodically. The interval of TD/medication induced movement disorder screening shall be determined by the practitioner/prescriber, Based on his or her clinical judgement and standard of care. It is the responsibility of the provider agency to maintain documentation of the screening (e.g., date and findings) in the service record of the person supported. Agency staff should report to the practitioner/prescriber any observed changes in the person supported, 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 individual are facilitated by an Independent Support Coordinator (ISC) or a DDA Case Manager (CM), depending upon the 1915(c) Waiver in which the member is enrolled.

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

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

Population Health

Population Health addresses acute health needs or risks which need immediate attention. Assistance provided to individuals is short-term and time limited in nature. Activities may include, but are not limited to, assistance with making appointments, transportation, social services, etc. and should not be confused with activities provided through 1915(c) waiver Independent Support Coordination or 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) individuals receive appropriate Population Health and the adequacy and appropriateness of these interventions Based on stratification and setting.

6. Quality Monitoring for 1915(c)

BlueCare Tennessee will collaborate with Department of Disability and Aging (DDA) in its quality monitoring of 1915(c) waiver HCBS. DDA Quality Monitoring shall include all 1915(c) waiver services.

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) calendar 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:

- TennCare utilization reviews and audits of services.
- Audits conducted by the Tennessee Office of the Comptroller to evaluate TennCare' s performance in administering the waiver program.
- 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").
- 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:

- New Provider Support Process.
- Provider Performance Surveys.
- Individual Waiver-Specific Record Reviews.
- Fiscal Accountability Review (FAR).
- Personal Satisfaction Surveys.

- Reportable Event and Investigation (RE&I) Data Analysis.
- Complaint Resolution Tracking.
- Death Reviews.
- Provider Self-Assessments.
- Individual Experience Assessments.

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

Remediation must occur at all levels of the system. Individual findings will require provider and/or 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. Once the validation process is complete DDA will submit a summary and recommendations to the MCO. Any punitive actions against the provider will be determined and imposed by the MCO.

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

Systemic findings will typically require longer time periods to determine the cause of the systemic finding and develop system-wide remediation strategies. Systemic improvement strategies will be proposed by 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 DDA, TennCare, and CMS regulations, including the HCBS Settings Final Rule. To assist a new provider with these responsibilities, once a newly approved provider has a fully executed Provider Agreement, an individual of the RPST will begin to make periodic contacts with the new provider. The primary purpose of this process is to assist a new provider with administrative areas or program implementation applicable to HCBS regulations and Tennessee State law. RPST involvement in this process will continue at least until the initial Quality Assurance ("QA") consultative survey and thereafter as determined by the Regional Quality Management Committee ("RQMC").

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

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

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

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

Survey Tools

Outcomes and Indicators related to each Quality Domain have been incorporated into DDA Provider Performance Survey Tools. Individual survey tools have been developed for different provider types. Copies of current QA survey tools [1] applicable to specific provider types are available on the DDA website, https://www.tn.gov/disability-and-aging/about-us/divisions/office-of-quality-management/quality-assurance.html.

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

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

DDA QA staffs conduct annual surveys of all providers. Less frequent surveys may be conducted for provider agencies demonstrating ongoing proficient or exceptional performance in overall operation. When a provider achieves Three- or Four-Star status, DDA reduces the frequency of monitoring for the next review cycle. There are specific criteria for making decisions about the frequency of monitoring. DDA may determine that more frequent surveys are necessary to evaluate provider performance in ensuring health, safety, and welfare of people supported or to determine resolution of serious compliance issues. Providers achieving Two Star status continue to have annual surveys.

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

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

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

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

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

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

1. Submit required pre-survey information in the required format to DDA at least thirty (30) days prior to the survey start date.
2. Identify a staff individual's as DDA's contact during the survey process.

3. Notify all persons, involved family individuals, and legal representatives, as applicable, of the upcoming survey.
4. Notify all persons, involved family individuals, and legal representatives, as applicable, of the survey team's availability to discuss the survey processes or services received during the survey.

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

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

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

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

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

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

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

Individual Record Reviews ("IRRs") are conducted during each waiver year to collect data demonstrating compliance for three (3) of the six (6) federally mandated waiver assurances: Level of Care, Service Plan, and Health and Welfare. IRRs are conducted by DDA QA staff. DDA is required to conduct these reviews annually.

During each waiver year, a statistically valid random sample of people will be selected for review from each waiver program.

For each person selected, a record review will be conducted by DDA QA staff utilizing a data collection instrument design Based on federally mandated waiver assurances and CMS-approved performance measures. The current data collection instrument is available on the DDA website.[5]

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

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 the BlueCare Tennessee.

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:

The TennCare, DDA, or MCO employee 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. The DDA employee identifying the immediate jeopardy situation or other DDA staff available will notify the DDA Regional Office Director or designee of the immediate jeopardy situation and forward a copy of the immediate jeopardy notice when completed. The DDA 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. The DDA employee will send a copy of the immediate jeopardy notice to the person's ISC/CM. The DDA employee will assure that a REF is completed, and the Investigations Unit is notified of the situation. The provider will notify the person's legal representatives and/or involved family individuals. 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 individual's 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 the DDA website. The PTP survey involves face-to-face

[5] https://www.tn.gov/disability-and-aging/about-us/divisions/office-of-quality-management/quality-assurance.html

interviews with persons and/or family individuals conducted by an independent evaluator employed by the contractor.

The contractor works with the 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 people supported and families. Providers are also required to have an identified complaint contact person and to maintain documentation of all complaints filed.

Reportable Event and Investigation data is maintained by the DDA.

1. Types and numbers of reportable events 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 the DDA website.[6]

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

The Statewide Quality Management Committee ("SQMC") is comprised of management level staff of all units within the Central Office and includes representation from each Regional Office. This group meets monthly and reviews statewide data to determine trends and initiate follow-up actions if warranted. Additionally, information as to actions taken by the RQMC in response to specific provider performance or other issues is reported to the SQMC, which ensures statewide consistency and maintains oversight of regional QM activities.

BlueCare Tennessee will participate in the monthly RQMC and SQMC meetings when surveys are reviewed, and recommendations are made to BlueCare Tennessee regarding what actions should be taken. If the issue identified multiple individuals supported, BlueCare Tennessee 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 BlueCare Tennessee. Any punitive actions such as sanctions will be determined and imposed by BlueCare Tennessee 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 QA Domain 2 (Individual Planning and Implementation), Domain 3 (Safety and Security), Domain 5 (Health) and/or Domain 9 (Provider Capabilities and Qualifications). New providers will be assisted in all domains. Activities of the RPST are reported regularly to the RQMC.

[7]https://www.dropbox.com/s/xxnm5hue1y8obqw/90.1.2%20-%20Death%20Reporting%20and%20Comprehensive%20Death%20Review.pdf?dl=0

7. 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 DDA, 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. 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 people supported. Situations that may result in MTA include, but are not limited to:

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

All Technical Assistance and recommendations will be shared with BlueCare Tennessee by DDA as will information and results of any consultations.

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 BlueCare Tennessee. 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.

[7] For additional information on how performance is scored, go to the DDA web site, Quality Management page, Survey Tools, Annual Quality Assurance Survey Report Card. https://www.tn.gov/disability-and-aging/about-us/divisions/office-of-quality-management/quality-assurance.html

1. Within ten (10) calendar 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 that is developed in collaboration with the RPST once a provider is placed on MTA. This document outlines specific findings, the providers plan for correcting them, monthly status updates from the provider, and any RPST feedback.
    - The S-CAP, once completed, will be reviewed by both DDA and the BlueCare Tennessee, who will work together to set the timeframes for completion.

3. 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.
4. 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.
5. During the next ninety (90) calendar days the provider will continue to work in collaboration with the RPST on MTA. The RPST will utilize various TA techniques, such as process mapping, side-by-side assessment, training on specific topics, etc.
6. A validation review will be scheduled to assess the provider's progress within ninety (90) calendar days of acceptance of the S-CAP. A validation tool will be utilized and consist of a subset of essential quality indicators from the QA Survey Tool; and will be customized to the provider Based on the performance issues which have resulted in MTA. The validation tool is individually designed for the provider requiring TA. It consists only of outcomes and indicators and interpretive guidance taken from the QA Survey Tool. It is not a new QA tool or checklist.
7. 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.

8. If there are extenuating circumstances after the first 90-day extension, e.g., change in director or senior management, natural disasters (fire, tornado), etc.; and compliance is still not achieved, SQMC may authorize an additional 90-day extension, prior to the imposition of benchmarks.
9. If the provider is not making progress, the RQMC shall recommend to the SQMC further administrative actions, up to and including termination of Provider Agreement.

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.

8. Electronic Visit Verification (EVV) System

The EVV system is an electronic system used to monitor an Individual's receipt and utilization of certain services. 1915(c) Waiver providers will continue to utilize DDA's required EVV vendor. DDA will administer and monitor 1915(c) Waiver provider's EVV Compliance.

9. Billing and Claims Submission

The 1915(c) payment of claims will transition to the MCOs with and effective date of 7/1/2024 (pending CMS approval). 1915(c) HCBS claims will be handled by MCOs that operate as administrative service organizations/fiscal agents/contracted vendors. 1915(c) dental claims will be handled by DBM that will operate as an administrative service organization/fiscal agent/contracted vendor. This 7/1/24 claims transition date is not considered I/DD Integration.

Claims Status

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

Cost-Sharing and Patient Liability

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

Patient Liability

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

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

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

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

BlueCare Tennessee 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.

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

If a 1915(c)-waiver individual 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, BlueCare Tennessee may request to no longer provide long-term services and supports to the individual.

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

1915(c) Fiscal Accountability Reviews (FAR) and TennCare Utilization Reviews (URs)

Independent Audit:

The current 1915(c) FAR process will continue and DDA will share the results with BlueCare. BlueCare will collaborate in the recoupment/rebilling process as applicable. BlueCare will attend the monthly SQMC meetings and receive provider results of Annual Quality Assurance reviews. Letters and notifications of Utilization Reviews that TennCare LTSS conduct will be provided to BlueCare for reviews and assurance that the audits were conducted as required per the CRA. Under the 1915(c) waivers, Utilization Reviews (URs) are conducted by the TennCare LTSS Intellectual Disabilities (ID) Services team for all 1915(c) waiver service providers with annual billing of less than $500,000 to ensure that 1915(c) services are appropriately documented and billed. Providers over the $500,000 threshold may also be reviewed.

The UR process includes a review of the approved service plan, a review of the billing documents and supporting documentation, and a comparison of all documents to adjudicated claims. Identified inconsistencies are documented and researched, and providers are given the opportunity to provide (not re-create) additional documentation to support services billed. Unsupported and/or inappropriate payments (Questionable Findings) typically result in recoupment.

If the provider agrees with the Questionable Findings, if the additional documentation provided does not fully support the services billed, or if there is no response from the provider within five (5) business days, LTSS ID staff send a rebill/recoupment instruction letter to the provider, which instructs the provider to submit corrected billing documentation to DDA to initiate the recoupment. LTSS ID staff track these rebill letters in a collaboration with DDA regional offices until they receive documentation of official recoupment.

Upon implementation of MCOs processing provider payments, DDA will no longer coordinate or process UR recoupments or rebilling for dates of service after 07/01/2024. BlueCare will be copied on provider UR letters/emails to initiate provider submission of corrected billing. Upon receipt and approval, BlueCare will process the recoupment/rebilling.

BlueCare will ensure that the collection of 1915(c) waiver patient liability, as determined by TennCare and in accordance with TennCare policy, that no Medicaid funds are expended for room and board in home and community Based residential settings.

BlueCare will monitor and safeguard the personal funds of members consistent with federal HCBS Settings Rule requirements.

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 individuals for amounts other than applicable TennCare cost-sharing or patient liability amounts for covered services, including services that the state or BlueCare Tennessee 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 individual 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 individual 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 individual about private payment. Once the provider bills BlueCare Tennessee 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 individual.

➢ If the individual's TennCare eligibility is pending at the time services are provided and if the provider informs the person, he or she will not accept TennCare assignment whether eligibility is established retroactively.

- Regardless of any understanding worked out between the provider and the individual about private payment, once the provider bills BlueCare Tennessee for the service, the prior arrangement with the individual becomes null and void without regard to any prior arrangement worked out with the individual.

➢ If the Individual'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 BlueCare Tennessee 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 more than an enrollee's benefit limit, and the provider complies with applicable TennCare rules and regulations.

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

10. Provider Grievance and Appeals

Providers may access the BlueCare Tennessee Medicaid Provider Manual via the BlueCare Tennessee provider portal, https://provider.bcbst.com/tools-resources/manuals-policies-guidelines > Resources> Polices, Guidelines and Manuals> Provider Manual (Medicaid). BlueCare Tennessee's Provider Complaint Procedures are outlined within the BlueCare Tennessee Provider Manual for Medicaid Services.

Provider Responsibilities for Complaint Resolution

Providers are required to establish a complaint resolution process to address complaints submitted by individuals 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 the 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 individuals 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 individual 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 individual.
5. Agency and ISC involved.
6. Description of complaint.
7. Description of Resolution (complainant confirmed).
8. Date of Resolution.

Upon admission providers must notify everyone, family individual(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 individuals and their contact information. Providers must inform people supported 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 the 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 the DDA Complaint Resolution System[8] 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

8 Reference DIDD policy 10.2.8 Complaint Resolution System
https://www.tn.gov/content/dam/tn/DIDD/documents/policies/10/10.2.8%20-%20Complaint%20Resolution.pdf

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.

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 BlueCare Tennessee, the ISC and/or DDA Case Manager when the provider is no longer willing or able to provide services to an individual, including the reason for the decision, and to cooperate with the Individual's Independent Support Coordinator or DDA Case Manager to facilitate a seamless transition to alternate providers.

When a 1915(c) waiver HCBS provider change is initiated for an individual, a provider must, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the individual in accordance with the Individual's person-centered support plan, as appropriate until the individual has been transitioned to a new provider, as determined by BlueCare Tennessee, the ISC and/or the DDA Case Manager, or as otherwise directed by BlueCare Tennessee, the ISC and/or DDA Case Manager, which may exceed sixty (60) days from the date of notice to BlueCare Tennessee unless the individual refuses continuation of services, the Individual'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. BlueCare Tennessee shall clearly document any individual refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the individual and/or the staff will result in services not being delivered. Prior to discontinuing service to the individual or prior to Provider termination of its Provider Agreement, as applicable.

Provider will be required to:

- Provide a written notification of the planned service discontinuation to the individual, his/her conservator or guardian, and his/her support coordinator, no less than sixty (60) days prior to the proposed date of service or Provider Agreement termination.
- Obtain BlueCare Tennessee, the ISC and/or the DDA Case Manager's approval in the form of a signed PCSP, to discontinue the service and cooperate with transition to any subsequent, authorized service provider as is necessary; and
- Consult and cooperate with BlueCare Tennessee, the ISC and/or the DDA Case Manager in the preparation of a discharge plan for all individuals 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 individual in accordance with applicable federal and state requirements and the Individual's plan of care or person-centered support plan, as appropriate as authorized by the 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 individual 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 individual or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service – electronic visit verification that fully comports with the 21st Century Cures Act and TENNCARE requirements shall be deemed sufficient to meet this requirement;
- Require 1915(c) waiver HCBS providers, as applicable, to use the electronic visit verification system specified by DDA in accordance with the DDA requirements.
- Require that upon acceptance by the 1915(c) waiver HCBS provider to provide approved services to a individual as indicated in the Individual'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 Individual's person-centered support plan, as appropriate, including the amount, frequency,

duration and scope of each service in accordance with the Individual'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 with Intellectual Disabilities (ICF/IID)

A. Introduction

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

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

Individuals 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 individual 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 individual 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

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

Prior to approval of Medicaid reimbursement in an ICF/IID, a person must complete the Community Informed Choice process to explore all options available to them in the community and to explore all options available to them in the community and to receive services in the most integrated setting appropriate.

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

BlueCare Tennessee is responsible for providing the following care coordination to individuals receiving services in an ICF/IID:

- Attend the annual treatment planning meeting and conduct the Level of Care Reassessment (LOCR). The ICF/IID contact must contact the MCO staff 30 days prior to the scheduled meeting.
- Coordinate with the ICF/IID as necessary to facilitate access to physical health and/or behavioral health services needed by the individual and to help ensure the proper management of the Individual's acute and/or chronic health conditions, including services covered by BlueCare Tennessee 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 Individual's PAE submission with a level of care determination and notification to TENNCARE; and 2) facilitate transitions to CHOICES which shall include (but is not limited to) timely notification to TENNCARE; and
- At a minimum, BlueCare Tennessee considers the following a potential significant change in needs or circumstances for individuals residing in an ICF/IID and contact the ICF/IID to determine if a visit and reassessment is needed:

- Reportable event 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

B. 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 individual fully understand the full array of community-Based options available to meet the Individual's needs, and having been fully informed, affirmatively chooses the institutional placement.

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

C. Coordination of Benefits for ICF/IID

BlueCare Tennessee will ensure continuity and coordination among physical health, behavioral health, and ICF/IID Providers. For ICF/IID Providers, the Individual'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.

BlueCare Tennessee 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.

D. Reimbursement for ICF/IID

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

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

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

E. Billing and Claims Submission

1. Electronic Submission

BlueCare Tennessee will be responsible for the payment of all LTSS services provided to individuals with I/DD, including services provided to individuals in an ICF/IID effective 07/01/24.

Claim Submissions for ICF/IID services will be submitted to BlueCare Tennessee. BlueCare Tennessee will pay these claims as outlined in the claims adjudication process.

BlueCare Tennessee 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 individual 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 BlueCare Tennessee receives notification from TennCare of the Individual's eligibility/enrollment.

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

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

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

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

2. Registering with Availity

If you choose to submit directly through Availity but are not yet a registered user, go to https://www.availity.com and select **Register**. The registration wizard will lead you through the enrollment process. Once complete, you will receive an email with your login credentials and next steps for getting started. If you have any questions or concerns, please contact Availity at 1-800-AVAILITY (1-800-282-4548).

It is our priority to deliver a smooth transition to Availity for our EDI services. If you have questions, please contact your Provider Relations representative or Provider Services at 1-800-454-3730.

F. 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.

1. 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/people supported 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/person supported in submission of a timely appeal request, assisting the applicant/person supported in preparing for the appeal hearing, assisting in making arrangements for a telephone or "in-person" hearing, assisting the applicant/person supported 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.

2. 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.

3. Provider Responsibilities in Maintaining TennCare Compliance

Providers have the responsibility to maintain compliance requirements as defined in the TennCare rules. Provider responsibilities include, but are not limited to:

1. Ensuring that services are provided in full as authorized in the Plan of Care (i.e., Individual Program Plan).
2. Services must be provided consistently and timely, ensuring that there are no gaps in service delivery. There must not be any act or omission which would impair the quality, timeliness, or availability of authorized services. Failure to provide services in accordance with these requirements may result in sanctions or recoupment of funds by the 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 individuals 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 individual 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 individual 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.

Contact Information

For Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), please call BlueCare Tennessee Provider Services at 1-866-840-4991 for precertification/notification, health plan network information, individual 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.

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

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

Patient Liability in an ICF/IID

BlueCare Tennessee will delegate collection of patient liability for individuals 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 individual who fails to pay his or her patient liability and for whom the ICF/IID can demonstrate to the BlueCare Tennessee that it has made a good faith effort to collect payment.

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

Contractor Risk Agreement Flow-Down Provisions

Provider shall meet the applicable minimum requirements specified in Provider Administration Manual, Section XII. Highlights of Provider Agreement, subsection C: TennCare/Subcontractor Provider Agreement Requirements. In addition, the ICF/IID Provider (herein referred to as "Provider") must also comply with the following:

1. Provider shall promptly notify BlueCare Tennessee, and/or State entity as directed by TENNCARE, of a member's request for admission to the ICF/IID or when there is a change in a member's known circumstances and to notify BlueCare Tennessee , and/or State entity as directed by TENNCARE, prior to a member's discharge;
2. Provider shall not admit any person to an ICF/IID for whom Medicaid reimbursement will be sought prior to completion of a Community Informed Choice process as prescribed by TENNCARE, and approval of such admission by the State;
3. Provider to provide written notice to TENNCARE and BlueCare Tennessee in accordance with state and federal requirements before voluntarily terminating the agreement and to comply with all applicable state and federal requirements regarding voluntary termination;
4. Provider shall notify BlueCare Tennessee prior to beginning to develop an involuntary discharge plan and shall consult with BlueCare Tennessee's IDD team to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate, including reasonable time to prepare the member and his/her parents or guardian for discharge or transfer;
5. Provider shall notify the member and/or the member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements, including involving the member and their family or legal guardian in planning for any transfer or discharge. This process must include providing a summary of the member's course of stay in the ICF/IID, a final summary of the member's developmental, behavioral, social, health and nutritional status, and include the current status of the objectives listed in the member's IPP as well as a post-discharge plan of care;
6. Provider shall accept payment or appropriate denial made by BlueCare Tennessee (or, if applicable, payment by BlueCare Tennessee that is supplementary to the member's third party payer) plus the amount of any applicable patient liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served;

7. Provider's responsibilities and prohibited activities regarding patient liability (see Sections A.2.6.7 and A.2.21.5 of this CRA), include but are not limited to collecting the applicable patient liability amounts from members residing in an ICF/IID, notifying BlueCare Tennessee if there is an issue with collecting a member's patient liability, and making good faith efforts to collect payment;
8. Provider shall conduct timely certification and recertification (as applicable) of the member's level of care eligibility for ICF/IID services and level of need for and receipt of continuous active treatment, and cooperate fully with BlueCare Tennessee in the completion and submission of the level of care assessment;
9. Provider shall submit complete and accurate PAEs that satisfy all technical requirements specified by TENNCARE, and accurately reflect the member's current medical and functional status. Provider shall also submit all supporting documentation required in the PAE and required pursuant to TennCare rules;
10. Provider shall notify BlueCare Tennessee of any change in a member's medical or functional condition that could impact the member's level of care eligibility and level of need for and receipt of continuous active treatment;
11. Prover shall 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 (6) months or more frequently if indicated at the time of assessment, submitted to BlueCare Tennessee for review and approval, and monitored by BlueCare Tennessee on an ongoing basis to ensure that it is implemented and that utilization of ICF/IID services continues to be appropriate for each of BlueCare Tennessee 's members served in the facility;
12. Provider shall 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 BlueCare Tennessee as needed to facilitate timely access to medically necessary services beyond the scope of the ICF/IID benefit;
13. Provider shall comply with state and federal laws and regulations applicable to ICFs/IID as well as any applicable federal court orders, including but not limited to the American with Disabilities Act and those that govern admission, transfer, and discharge policies;
14. Provider shall cooperate with BlueCare Tennessee in developing and implementing protocols as part of BlueCare Tennessee 's ICF/IID diversion and transition plans pursuant to the Americans with Disabilities Act, which shall, include, at a minimum, the ICF/IID's obligation to promptly notify BlueCare Tennessee upon request for admission of an eligible member regardless of payor source for the ICF/IID stay; refusal of admission of any person to an ICF/IID for whom Medicaid reimbursement will be sought pending completion of a Community Informed Choice process as prescribed by TENNCARE, and approval of such admission by the State; how the ICF/IID will assist BlueCare Tennessee in identifying current ICF/IID residents who may want to transition from ICF/IID services to home and community-based care; the ICF/IID's obligation to promptly notify BlueCare Tennessee regarding all such identified members; and how the ICF/IID will work with BlueCare Tennessee in assessing the member's transition potential and needs, and in developing and implementing a transition plan, pursuant to 42 C.F.R. 483.440;
15. Provider shall have on file a system designed and utilized to ensure the integrity of the member's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;
16. Provider shall immediately notify BlueCare Tennessee of any change in its license to operate as issued by DDA as well as any deficiencies cited during the federal certification or licensure process;
17. If Provider is decertified (i.e., it's participation in the Medicaid program is terminated by the Tennessee Department of Health or the Centers for Medicare and Medicaid Services) BlueCare Tennessee 'S provider agreement with such ICF/IID will automatically be terminated; and
18. The provider agreement shall be assignable from BlueCare Tennessee to the State, or its designee, at the State's discretion upon written notice to BlueCare Tennessee and the affected ICF/IID provider. Provider shall be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of BlueCare Tennessee.

All 1915 (c), Employment and Community First (ECF) CHOICES and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

A. Contracting, Credentialing and Recredentialing

DDA is responsible for initial credentialing and recredentialing for all 1915c, Employment and Community First (ECF) CHOICES providers.

Effective February 1, 2023, DDA is responsible for the initial credentialing and recredentialing of all 1915c providers, Katie Beckett Part A and Part B providers, and for both ECF CHOICES and CHOICES for providers who apply to do both.

Beginning on May 1, 2023, DDA will be responsible for the recredentialing Katie Beckett Part A services and for both ECF CHOICES and CHOICES for providers who are contracted for both. These recredentialing efforts will be in addition to the current DDA recredentialing responsibilities for the 1915c, and Katie Beckett Part B services.

Starting May 1, 2023, the MCOs will be responsible for initial credentialing and recredentialing of CHOICES only providers.

If there is a provider already in the process of credentialing or recredentialing, the MCOs will complete this process, similar to the roll-out last year when DDA began credentialing/recredentialing ECF CHOICES

The consolidated process will, as applicable, meet the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs and ensure that all long-term services and supports providers, including those credentialed/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, or in policies or protocols.

Beginning on or after July 1, 2022, as directed by TennCare (which may vary by service type), BlueCare Tennessee 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, while ensuring BlueCare Tennessee will have an adequate network to initiate and consistently deliver services in accordance with each Individual's PCSP or IPP. This will 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.)

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

BlueCare Tennessee will contract with a highly preferred I/DD provider (Based on contracting standards) to address identified network gaps—related to the ability to deliver needed services without gaps in care or to address quality (including quality outcome) concerns. In these instances, an MCO would be expected to either contract with an identified provider, or to contract with an alternative provider that is equally preferred and able to fill the identified gap.

Ongoing MLTSS Program HCBS Providers must be recredentialed annually. All other ECF CHOICES and 1915(c) Waiver HCBS providers (e.g., pest and assistive technology) must be recredentialed at a minimum every three years but will have an annual site visit. Per TennCare at a minimum, credentialing of LTSS

providers will include the collection of required documents, disclosure statements, and verification that a provider has:

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

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

1. 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 BlueCare Tennessee must be accessible to all individuals.

2. New Provider Training

Upon enrollment into BlueCare Tennessee's network every provider will go through Orientation and Training, no later than 30 days post contract being issued, unless requested by the provider. Orientation and Training will include all trainings as outlined in the DDA Credentialing Standards Protocol.

B. Reportable Event Management

In HCBS programs, there are three (3) categories of Reportable Events: Tier 1, Tier 2, and Additional Reportable Events and Interventions. The type of Reportable Event dictates the reporting requirements and process that must be followed by the provider, BlueCare, and DDA, as outlined in the REM Operational Protocol.

Providers are to comply with the requirements specified in the REM Protocol and Definitions document.

C. Fraud, Waste and Abuse

First Line of Defense Against Fraud

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

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

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

Presentation of a individual identification card does not guarantee eligibility; providers should verify a Individual'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 1-800-454-3730.

Providers should encourage individuals to protect their identification cards as they would a credit card, to carry their health benefits card at all times and report any lost or stolen cards to our company as soon as possible. Understanding the various opportunities for fraud and working with individuals to protect their health benefit identification card can help prevent fraudulent activities. If you or a patient suspect identification theft, call our BlueCare Tennessee compliance hotline at 1-800-433-3982. Providers should instruct their patients who suspect identification theft to watch the Explanation of Benefits (EOB) for any errors and contact individual services if something is incorrect.

1. Reporting Fraud, Waste and Abuse

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

You can report your concerns by:

- Visiting our website and completing the Report Waste, Fraud and Abuse form.
- Calling Provider Services.
- Calling our Special Investigations Unit fraud hotline at 1-866-847-8247.

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

Examples of Provider Fraud, Waste and Abuse:

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

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

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

Examples of Individual Fraud, Waste and Abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use the Individual's identification card
- Obtaining controlled substances from multiple providers

- Relocating to out-of-service plan area
- Using someone else's identification card

When reporting concerns involving an individual include:

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

2. Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that subcontracted to outside entities. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include but is not limited to:

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

Acting on Investigative Findings

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

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

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

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

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

3. 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 individual information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary individual information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of individual information. Our company may request information to conduct business and make decisions about care such as a Individual'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 individuals who need individual 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 individual information (e.g., Excel spreadsheets with claim information; such information should be mailed or faxed.)
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box or department at our company.
- Our company voicemail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of individual information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the provider's name, address and TIN or Individual'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.

MLTSS Provider Manual Change Document

MLTSS Provider Manual Updates

Updated 20250401

Correction	Page	Description
20250401.01	1-119	Various formatting, word choice and grammatic changes made throughout the document.
20250401.02	25	H. ECF CHOICES Provider Agreement Requirements • Added a section titled: Community Living Support (CLS) Ombudsman
20250401.03	109	Intermediate Care Facilities with Intellectual Disabilities (ICF/IID) A. Introduction Community Informed Choices ➢ Added a bullet stating: Attend the annual treatment planning meeting and conduct the Level of Care Reassessment (LOCR). The ICF/IID contact must contact the MCO staff 30 days prior to the scheduled meeting.

Updated 20250101

Correction	Page	Description
20250101.01	1-125	Formatting and grammatic changes throughout the document.
20250101.02	3-7	Updated Table of Contents
20250101.03	27	H. ECF CHOICES Provider Agreement Requirements • Added a section titled: Money Follows the Person (MFP) Provider Incentive
20250101.04	64-65	D. Member, Benefits, Supports & Covered Services • Reworded multiple benefits in the table
20250101.05	72-73	Exploration (added and Self Employment Exploration) – corrected heading. • Grammatic changes in this section. • Corrected time frames in this section.
20250101.06	116	Formatting change in the benefit table.

Update 20241001

Correction	Page	Description
20241001.01	Various	Throughout Manual, updated DIDD to DDA and links where applicable. Eff. 7/1/24, DIDD is now known as The Department of Disability and Aging (DDA) instead of DIDD (Department of Intellectual and Developmental Disabilities).
20241001.02	1	Updated Title of Cover Page by adding "MLTSS" for clarification purposes
20241001.03	2	Updated title of section from "Welcome" to "Managed Long-Term Services and Support (MLTSS)"
20241001.03	5	ECF CHOICES Program – TOC: Updated title of section G. by replacing "employment" to "training"

20241001.03	14 28 35 41	Employment and Community First CHOICES Program: - C.1. Benefit Grid under "Supported employment-individual employment support – Added "Integrated Employment Path Services" as suggested by TDCI. - H. Definitions – Added "Religious and Ethical Directives" with language. - I.8.3rd set of bullets – Updated bullet #3 by changing $1,500,000.00 to $1,000,000.00. - J. ECF CHOICES B&R guidelines grid – Self-Employment Startup: Updated description column by replacing "individualized, integrated employment" with "self-employment"
20241001.04	59 62 65 66 71 75 78 82 85 86 86 88 103 104 110	1915© Waiver Programs: - B. Added DDA contact info for 1915c Waiver providers per TDCI suggestion - D. Member Benefits, Supports, & Covered Services o Grid – Added "Exploration for Individualized Integrated Employment and Exploration for Self-Employment" to 12th row per TDCI suggestion. o I. Service Definitions - e. updated with DDA link per TDCI suggestion. o 2. Therapeutic and therapy related services – updated link to DDA site per TDCI suggestion. o II. Employment Services ▪ 1. Supported Employment – Individual, Exploration: Updated language per TDCI suggestion. ▪ 2. Day Services and Other Service Options – Homebound Support Services: Added Employment & Day Services link as suggested by TDCI. o III. Person Centered Support Plan ▪ The Circle of Support – Added "who participate in" and removed "hip of" in first paragraph. o VIII. Rights – Updated edhr.pdf link in footnote - E. Provider Requirements o Removed footnote for Council on Quality and Leadership reference and link. o Death Reporting and Review Policy – Removed Interim process language and reference to Council on Quality and Leadership with link. o 1. Provider Agreements– Added language for "Religious and Ethical Directives" as 3rd and 4th paragraphs. o 2. Provider Roles and Responsibilities – 6. Updated language and link. o 9. Billing and Claims Submission – Removed language under Independent Audit (5th and 8th paragraphs) per TDCI suggestion. - E. Billing and Claims Submission o 1. Electronic Submission – Updated language in 1st paragraph to include an eff. date of 7/1/24.

Update 20240701

Correction	Page	Description
20240701.01	Various	No Material Changes. Formatting updates only.

Update 20240401

Correction	Page	Description
20240401.01	9	Updated language per TDCI review from 1st submission
20240401.02	10	Updated language per TDCI review from 1st submission
20240401.03	14	Updated language in Table per TDCI review from 1st submission
20240401.04	22	Updated language per TDCI review from 1st submission
20240401.05	28	Section H. ECF Choices Provider Requirements- added the following language to 1st paragraph- All provider agreements contracts or templates and revisions thereto must be approved in writing in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof. Provider agreements shall not contain covenant-not-to-compete requirements or terms requiring a provider to not provide services for any other TennCare MCO. Furthermore, BlueCare Tennessee shall not execute any provider agreements that contain compensation terms that discourage providers from serving any specific eligibility category or population covered by the CRA.
20240401.06	23-33	Updated language per TDCI review from 1st submission
20240401.07	36	Updated language to ISCT per TDCI review from 1st submission
20240401.08	38	Updated language per TDCI review from 1st submission
20240401.09	43	Updated language per TDCI review from 1st submission
20240401.10	44	I. ECF CHOICES Provider Contracting/Credentialing- added paragraph language to the end of the section- In the event the provider contract is terminated because of a change of ownership, BlueCare Tennessee shall remain obligated to pay for reimbursable services rendered prior to termination of the contract and that become due after the contract is terminated subject to timely filing requirements
20240401.11	46	Updated language per TDCI review from 1st submission
20240401.12	48-61	Updated Table language per TDCI review from 1st submission
20240401.13	69	Updated language per TDCI review from 1st submission
20240401.14	71	Updated language per TDCI review from 1st submission
20240401.15	74	Updated language per TDCI review from 1st submission
20240401.16	79	Updated language per TDCI review from 1st submission
20240401.17	83-86	Updated language per TDCI review from 1st submission
20240401.18	88	Updated language per TDCI review from 1st submission

20240401.19	91	Updated language per TDCI review from 1st submission
20240401.20	92	Updated language per TDCI review from 1st submission
20240401.21	98	Updated language per TDCI review from 1st submission
20240401.22	103	Updated language per TDCI review from 1st submission
20240401.23	107-113	Updated language per TDCI review from 1st submission
20240401.24	115	Updated language per TDCI review from 1st submission
20240401.25	136-137	Added Section "Contractor Risk Agreement Flow- Down Provisions language with 18 bullets added. Updated language per TDCI review from 1st submission

Update 20240101

Correction	Page	Description
20240101.01	2	Grammatical update
20240101.02	8	Grammatical updates- multiple, added "Is" and updated punctuation from period to comma
20240101.03	9	Grammatical updates- multiple, updated punctuation from period to comma. Updated HCBS acronym to Home and Community Based Services & NF to Nursing Facility
20240101.04	10	Grammatical updates- multiple
20240101.05	11	Grammatical updates- multiple
20240101.06	12	Grammatical update
20240101.07	14	Grammatical update
20240101.08	16-17	Grammatical updates- multiple
20240101.09	19-20	Grammatical updates- multiple
20240101.10	22-27	Updated paragraph with new training information and deleted prior information.
20240101.11	36-37	Updated and added new language paragraphs
20240101.12	39-40	Grammatical updates-multiple
20240101.13	42	Grammatical update
20240101.14	43	Added new paragraph
20240101.15	45	Grammatical update
20240101.16	49-51	Grammatical updates- multiple
20240101.17	54	Grammatical update
20240101.18	61	Added "an exclusion checks, as applicable"
20240101.19	62	Added "and TennCare's Terminated Provider List, Social Security Death Master File," Added, " including results from criminal background checks, registries and exclusions," Also, grammatical update
20240101.20	62	Grammatical updates- multiple
20240101.21	64-65	Grammatical updates-multiple
20240101.22	66-67	Grammatical update and two new paragraphs of language added
20240101.23	70	Grammatical updates-multiple, also website link added

20240101.24	72	Added four new sections of language to chart.
20240101.25	74-75	Updated punctuation, also four new benefits added with all applicable language included
20240101.26	77	Website link added
20240101.27	79	Updated website link
20240101.28	80	Grammatical update
20240101.29	82-86	Grammatical updates- multiple; added new language for Benefits Counseling, Job Development, Exploration and Discovery
20240101.30	88-90	Grammatical update; deleted all ICF language in Short Term Stay section
20240101.31	92	Grammatical update
20240101.32	94	Grammatical update
20240101.33	99	Updated #13 and added #14 and additional language.
20240101.34	101-102	Added new language for Provider Agreements #1
20240101.35	104	Added “an exclusion checks” and “and TennCare’s Terminated Provider List, Social Security Death Master File-SAM” under #3. Background Checks
20240101.36	103-104	Grammatical update; updated Background Checks language
20240101.37	105-107	Grammatical update; updated website link
20240101.38	109-111	Grammatical update
20240101.39	116	Grammatical update
20240101.40	118-120	Grammatical update
20240101.41	122-128	Grammatical updates-multiple; updated language from State Continuous Quality Improvement to SQMC acronym
20240101.42	133-136	Grammatical updates-multiple

Update 20230401

Correction	Page	Description
20230401.01	39	Technology Providers section added
20230401.02	61	Additional FEA language added
20230401.03	92	FEA language added
20230401.04	96	Additional provider agreement language added
20230401.05	Multiple	Updated “Person-Centered Plan” to “Person-centered support plan” as needed throughout manual.
20230401.06	67	Updated bulleted language with who can enroll.
20230401.07	71	Updated link for Family Support Program
20230401.08	71	Updated language above the Criteria table for DD & ID
20230401.09	75	Spelled out “Behavioral Support Plan” with acronym
20230401.10	77-79	Updated language, and link for Waiver Service Definitions pdf
20230401.11	82	Removed language regarding employment data collection as suggested by DDA until further notice
20230401.12	83	Added “Day” to “Types of Services”
20230401.13	84-85	Added and removed language, as applicable
20230401.14	90	Replaced “1915(c)” with “SD”
20230401.15	93	Updated language, as applicable for Consumer Direction
20230401.16	97	Updated language for Death Reporting and Death Reviews

20230401.17	99	Updated language in 1st bullet
20230401.18	104	Updated title from “Pre employment services” to “Supported Employment Individual”
20230401.19	105	Updated link for Training Req for Provider Staff Categories.pdf
20230401.20	108	Updated 6th bullet
20230401.21	113&124	Updated language for reportable events, as applicable
20230401.22	41, 83	For Facility-Based Day Services - Replaced “services” with “supports” for consistency& accuracy.
20230401.23	40,42,44,91,127	Added/removed language for DDA/credentialing & re-process

Update 20220401

Correction	Page	Description
20220401.01	114-115	Patient Liability language added/ **Updated per deficiency received 2/11/22** – 1915c Fiscal Accountability Reviews (FAR) & TennCare Utilization Review (URs) section added

Update 20220101

Correction	Page	Description
20220101.01	13	Enabling Technology language added to grid
20220101.02	46	Addition to Assistive Technology title
20220101.03	57	Enabling Technology language added to grid
20220101.04	60	REM Language changed to approved vague language
20220101.05	64	Added language to REM section (ECF)
20220101.06	79	Employment Data Collection language modified
20220101.07	136	REM Language changed to approved vague language
20220101.08	142	MLTSS Provider Manual Change Document added