ENHANCED HCBS FMAP FUNDING
Frequently Asked Questions (FAQ), Part 2

General:

- **How will provider and members/families be informed of all of the different benefits provided in the Enhanced HCBS FMAP?**

TennCare has prepared a letter for individuals in each program for dissemination by the MCO or DIDD, as applicable. MCO Care/Support Coordinators, ISCs, and DIDD Case Managers will discuss the different benefit options with members and families, to ensure any needed benefits available are requested for the member. In addition, TennCare, MCOs, and DIDD will communicate all of the different benefits of the Enhanced HCBS FMAP to providers and members/families through a variety of channels and platforms (TennCare website, member newsletters, protocols, memos, etc.). AARP has also assisted in disseminating information to their membership—impacting those who may need services as well as family caregivers.

- **What happens if I didn't upload my attestation by the November 15 deadline?**

There is not a November 15 "deadline" to upload the form. The purpose of the November 15 date was to encourage providers to move quickly so MCOs could begin reprocessing the majority of claims at the higher rates.

As outlined in the rate increase memos: "For all providers submitting a completed form by November 15, 2021, MCOs are expected to begin processing new claims at the higher rates by December 6, 2021. MCOs will also commence automatically reprocessing claims with dates of service 7/1/21 and following with the goal of completing all adjustments as expeditiously as possible, and within no more than 60 days—by February 4, 2022. ***Providers not submitting a completed form by November 15, 2021 will be eligible for new rates once the form is submitted."***

- **I didn't upload my form by November 15. When can I expect to receive the new rates and retroactive payments?**

MCOs will receive reports from TennCare on a weekly basis showing which providers have uploaded their attestation forms. MCOs are expected to ***begin*** *processing new claims at the higher rates no more than three weeks after notification that the attestation is complete. MCOs are expected to* ***complete*** *reprocessing claims with dates of service 7/1/21 and following within no more than 60 days after receipt of notification that the attestation is complete.*

- **I have not received the instructions for uploading the form into PDMS. Where can I find that?**

The attestation form can be found on the LTSS website here: https://www.tn.gov/tenncare/long-term-services-supports/enhanced-hcbs-fmap.html

- **How can a provider get confirmation if an attestation was uploaded correctly?**

Providers can see documents that are uploaded and the status in PDMS following submission.

- **If a provider does <u>not</u> want to participate in the FMAP program, what do they need to do?**

If a provider decides to decline the enhanced funding to increase staff wages and other Enhanced HCBS FMAP funds, the provider simply takes no action. In this case, the provider will continue to receive the rates in effect as of June 30, 2021 and will not be eligible for any other parts of the Enhanced HCBS FMAP funds outlined in the Initial Spending Plan unless or until they complete and submit an attestation form.

However, it seems nearly unthinkable that a provider would not work through how to take advantage of these funds in a way that benefits both those providing and receiving services. If the concern is the fear that recurring expenditures will not be approved (know that they have already been requested), then there are other ways to distribute funds to the direct care workforce that would not obligate the provider beyond the FMAP funding period. While we are not prescribing the method by which funds are passed through to direct care staff, we strongly advise discussion with other providers about the different ways that agencies across the State plan to structure payments to their staff. Missing this opportunity in the current workforce environment seems ill-advised.

We have already requested recurring funding for this item, and while we cannot assure the outcome of the legislative budget process, we expect (and are certainly hopeful) that folks will want to see these important investments continue.

<u>2,000 New Employment and Community First CHOICES Members from the Referral List</u>

- **How will the slots be prioritized for enrollment?**

The 2,000 slots funded through the Enhanced HCBS FMAP funds are initially targeted to serve those individuals who are actively seeking services, have been waiting to receive services the longest, and who do not meet employment-related prioritization criteria—based on information gathered during the referral or any subsequent intake or review process. We are also contacting individuals who have been waiting for services the longest but are currently categorized as "deferred" to make sure they do not want to receive services at this time.

- **Why is the funding limited to 2,000 slots?**

This is the number of slots that had previously been recommended by the Governor and funded by the General Assembly for the FY 21 budget. These funds were lost as part of COVID-related budget impacts. Further, in addition to prioritizing this waiting list, based on stakeholder input, we wanted to also prioritize Family Caregiver Supports, Enabling Technology, wage increases for frontline HCBS staff and other investments in provider quality and capacity.

- **Will there still be people left on the ECF Referral list after the 2,000 slots are filled? If so, what is the plan to enroll them into the Employment and Community First (ECF) CHOICES program?**

Yes, we expect there will still be individuals on the ECF Waiting list after the Enhanced HCBS FMAP slots are filled. It is difficult to know how many that will be, as we are finding that some people are electing not to enroll at this time. TennCare and DIDD continue to work together on other opportunities to help eliminate the Referral List completely.

- **What happens to the 2,000 enrolled members when the ARP funding runs out on March 31, 2024?**

As part of FY 23 budget requests, TennCare is seeking recurring funding for the 2,000 new ECF CHOICES members from the referral list. If funded, ARP funds will be used to "buy back" the state's share for FY 23 and part of FY 24 (until the ARP funding ends). Shared savings from the TennCare III demonstration are another potential funding source for these recurring funds.

- **How will the upcoming I/DD Integration affect the enrollment of these individuals into the ECF program?**

There is no impact. The Employment and Community First CHOICES program is already part of the managed care program. I/DD Integration, which is a TennCare collaboration with the Department of Intellectual and Developmental Disabilities (DIDD), is a separate initiative from the Enhanced HCBS FMAP, and will integrate additional programs and services for people with I/DD into the managed care program.

- **How will an individual know if they are selected for one of the 2,000 slots?**

If an individual on the Referral List is selected for enrollment into ECF CHOICES they will be contacted by their selected MCO to begin the enrollment process. If an individual is not enrolled in TennCare, DIDD will be responsible for notification and initiation of the enrollment process. TennCare has weekly check-ins with each MCO and DIDD to ensure enrollments are occurring according to specified timelines.

Family Caregiver Supports

- **If the member does not utilize the entire $3,000 benefit by March 31, 2024, what happens to the remaining funds?**

*Not every person who is eligible is **expected** to receive these benefits or to receive the maximum of $3,000. The funding projected for these services is based on 80% of eligible individuals using 85% of the available benefit. TennCare will monitor utilization carefully in order to ensure that funding set aside in the Spending Plan for this purpose is sufficient based on actual demand, and to adjust the Spending Plan, if needed. This could affect the availability of funding for other purposes, depending on whether expenditures are more or less than projected.*

- **The Family Caregiver Supports benefit can only be used for specific services (depending on the program). Why aren't additional services allowed to be used for the $3,000 one-time benefit?**

Only specified services that will further enable the member's independence and/or support and sustain unpaid family caregivers may be approved.

- **Why is the Family Caregiver Supports benefit not available for a member who is receiving a LTSS residential service, including but not limited to, any level of Community Living Supports or Community Living Supports-Family Model, ACLF, Adult Care Home, Companion, Care, or Supported Living?**

*This is a specifically designed benefit to help **families** providing daily care to members who are living in the home with family, or if living outside the family home, still receive unpaid support from family. The goal is to help support and sustain family caregivers. Other assistance (in the form of increased wages and other incentive opportunities) are provided for the paid HCBS workforce.*

- **While meeting with the Coordinator/Case Manager to request the Family Caregiver Supports benefit, what if the Coordinator/Case Manager disagrees with the family/member? Will there be an appeal process for the family/member to receive this benefit?**

Yes, there will be an appeal process for individuals who are denied this benefit. In the event a request for any benefit available through the Family Caregiver Supports benefit is denied, the member will be notified of the denial in writing along with appeal rights in the same way as any other service request and denial. Appeals will be handled in the same way as all other service appeals in the applicable program.

- **Can you break down the new TennCare Family Caregiver Supports (FCS) protocol into plain language, please?**

A plain language notice has been developed for individuals in each program for dissemination by the MCO or DIDD. Copies of those notices are attached hereto. We are happy to answer any additional questions. The protocol is developed for purposes of operationalizing the benefit by the MCO and DIDD and is not intended to guide individuals and families in their decision making.

Enabling Technology as an added benefit

- **Why is Enabling Technology the only service being funded under the *Supporting Independence and Integration* Section in the initial Enhanced HCBS FMAP Spending Plan?**

Enabling Technology is the first (and currently only) service being funded under the Enhanced HCBS FMAP Plan specifically for Supporting Independence and Integration. This is because it is already available in the 1915(c) waivers and was planned for implementation in ECF CHOICES. This helps to ensure comparable access for those in CHOICES. This is a benefit that has significant potential to increase independence and safety in the community, improving quality of life for those we serve. The framework is already in place for this new service to be easily implemented and available for widespread use. If Enhanced HCBS FMAP funding is available, TennCare may introduce additional supports over the course of the Enhanced HCBS FMAP period.

- **What criteria determines if a specific technology (i.e., new technology) falls under the Enabling Technology benefit? If a member/family requests a technology that falls outside of that definition, do they have an appeal recourse?**

Each individual who is interested in Enabling Technology will complete a short survey to determine their needs and potential technologies that can be beneficial. A member may request a new piece of technology, however, that does not mean that it will automatically be approved. The survey helps determine if a new technology is needed to promote independence and community living. Enabling Technology covers a very wide range of services and products. However, like all other services and supports in HCBS programs, TennCare wants to provide services that the member truly needs and that will be beneficial to the member. As with any TennCare benefit, if the requested service is denied, the member will be notified in writing and given an opportunity to appeal.

- **Why is the Enabling Technology benefit limited to $10,000 for 1915(c) Waiver members and $5,000 for CHOICES and ECF CHOICES members?**

*Enabling Technology is limited to $10,000 per **two** years for 1915(c) waiver members, which is essentially the same as the $5,000 per year limit in CHOICES and ECF CHOICES.*

- **While meeting with the Coordinator/Case Manager to request this benefit, what if the Coordinator/Case Manager disagrees with the family/member? Will there be an appeal process for the family/member to receive this benefit?**

Yes, as noted above, there is an appeal process for family/members who are denied this (or any) benefit. In the event an appeal is filed for denial of Enabling Technology by a CHOICES or ECF CHOICES member, appeals will be handled in the same way as all other service appeals. The MCO is responsible for supporting the denial of Enabling Technology and also notifying DIDD (DIDD.Enabling. Technology@tn.gov) of the denial. In the event an appeal is filed for denial of Enabling Technology by a 1915(c) Waiver member, appeals will be handled in the same way as all other DIDD service appeals. DIDD is responsible for supporting the denial of Enabling Technology.

- **Is it mandatory that a provider offers Enabling Technology to their members?**

It is the decision of the person supported and his/her Circle of Support regarding whether Enabling Technology may be helpful in increasing safety and independence. Enabling Technology is typically offered through national vendors, so it is not a requirement that a local provider offer this support. The MCO or DIDD will ensure that a provider is available. However, given the incredible opportunities for increasing independence ET can offer, we strongly encourage all providers to begin learning more about ET and to explore how it may help them better support those they serve.

- **If providers need guidance when developing a plan to ensure oversight for remote support sites, will DIDD or TennCare be available to offer assistance?**

Yes. DIDD, TennCare, and the MCOs will share best practices and ensure that the necessary guidance is given for a successful implementation.

- **When is the deadline for Care Coordinators to complete the ET (enabling technology) form with the members? Will providers be involved in the process or will this be exclusive to member/CC?**

There is no deadline. ET will be part of the annual planning process. We encourage all providers to be involved in discussions related to ET opportunities for those they support.

Wage Increase for Frontline CHOICES and ECF CHOICES HCBS Workforce

- **How were the wage increases determined?**

The ARP Enhanced HCBS FMAP funds are being used to align reimbursement for comparable services across Medicaid HCBS programs and population, in order to support equitable pay increases for the common workforce that serves them. CHOICES and ECF CHOICES services targeted for rate increases 1) have a direct care component; and 2) are currently reimbursed at a lesser rate than is effective as of July 1, 2021 for comparable services delivered through the Section 1915(c) waivers.

- **Why weren't some CHOICES rates increased?**

CHOICES services targeted for rate increases 1) have a direct care component; and 2) are currently reimbursed at a lesser rate than is effective as of July 1, 2021 for comparable services delivered through the Section 1915(c) waivers. If the CHOICES rate for the comparable service is already reimbursed at a rate higher than in the 1915(c) waivers, the rate is not increased.

- **Why was respite not included in rate adjustment?**

CHOICES and ECF CHOICES services targeted for rate increases are currently reimbursed at a lesser rate than is effective as of July 1, 2021 for comparable services delivered through the Section 1915(c) waivers. The rate of payment for respite did not meet the criteria defined above.

- **Can you clarify why Critical Adult Care Homes, Level 2 were not included for the rate increase?**

*Adult Care Homes, Level 2 for individuals with Traumatic Brain Injury **were** included in the rate increases in the CHOICES program. The rate was increased from $139/day to $189/day. See rate memo here: https://www.tn.gov/tenncare/long-term-services-supports/enhanced-hcbs-fmap.html. Adult Care Homes, Level 2 for individuals who are Ventilator Dependent were not included. As described in the memo, the ARP Enhanced HCBS FMAP funds are being used to align reimbursement for comparable services across Medicaid HCBS programs and population, in order to support equitable pay increases for the common workforce that serves them. In this case, there is no comparable community-based service in other programs. The care is most comparable to our Enhanced Respiratory Care program—for individuals served in Skilled Nursing Facilities. In 2016, TennCare implemented a new value-based structure for chronic ventilator care in a SNF. Currently, a facility receives its base Medicaid rate—which covers "basic NF care, including room and board," as well as an add-on payment for chronic ventilator care, which is dependent on the facility's performance on specified quality measures. Those add-on payments range from $250-$350/day.*

If we take into account that room and board charges are NOT included in the $450/day rate for Level II Critical Adult Care Homes, this means that in many cases, we are already paying as much (if not more) to provide this care in the community than in an institution. The terms of our waiver do not allow us to pay for care in the community that is more expensive than comparable care in an institution. Thus, we could not increase these rates without running the risk that we might no longer be able to provide the benefit at all.

- **How does the FMAP affect the Meal Provider Program?**

The Meal Provider Program is not affected by the Enhanced FMAP Initial Spending Plan.

- **Why weren't 1915(c) rates included in the funding?**

The General Assembly has appropriated funding for rate increases in the Section 1915(c) waivers, including $48.6 million for FY 22, bringing DSP wages to $12.50 per hour. ARP Enhanced HCBS FMAP funds will be used to align reimbursement for comparable services across Medicaid HCBS programs and population, in order to support equitable pay increases for the common workforce that serves them. CHOICES and ECF CHOICES services targeted for rate increases 1) have a direct care component; and 2) are currently reimbursed at a lesser rate than is effective as of July 1, 2021 for comparable services delivered through the Section 1915(c) waivers.

- **If we already pay above the $12.50 rate, can we spend any of the dollars on employee training or upgrade the computers they use during fieldwork?**

*No. The sole purpose of this funding is to increase **wages** for frontline staff. If a provider is already paying $12.50/hour, the provider may explore how the funds can be invested to further increase the **wages** of frontline staff—such as retention bonuses, performance bonuses, mileage allowances, etc. provided that these are recurring (i.e., will occur on an annual basis to ensure that all of the funding is passed through to the direct support workforce), and that the combination of wage increases and other investments into the wages of the frontline staff account for all of the funding which must be passed through to the direct support workforce. While permissible, please note that mechanisms other than wage increases may increase the complexity of audit processes to ensure the funding has been passed through.*

- **If we increase our hiring, that increases background checks, reference check, and other costs so none of this money can be paid for these costs?**

*As provided in the rate increase memos, **"[a] wage factor is applied to account for provider related costs such as taxes."** This means that the provider is permitted to keep roughly 16.7% of the approved funding, which we expect is sufficient to cover these costs. Moreover, we expect that by offering a higher wage, turnover will be reduced, such that these kinds of expenses will also be reduced, offering additional financial relief for providers.*

- **Can we pay a monthly bonus which will increase the hourly rate to $12.50 or does the rate have to be paid per hour?**

*TennCare is not prescribing how the funds are passed through to the frontline workforce, just that they **must** be passed through in order to be eligible for the rate increase. Monthly recurring bonuses*

would be acceptable, but may increase the complexity of audit processes to ensure that the funding is used for its intended purpose.

- **Does the $12.50 per hour include taxes? Or is it 12.50 total payroll cost (including taxes)?**

$12.50 is the hourly wage we expect is accounted for in the reimbursement structure (based on methodologies for comparable services delivered through Section 1915(c) waivers). As provided above, a wage factor is built into the rate increase which is expected to cover the employer share of taxes, as well as leave, etc.

- **I know we have had many questions in regard to increasing to $12.50; however, can you clarify the 16.7% set aside for the payroll and taxes that's mentioned in the FAQ Set #1.**

In calculating rate increases, a wage factor of 1.2 (roughly 16.7%) was included for every dollar of wage increase to account for provider taxes and related expenses. The provider may keep up to 16.7% of the additional revenues resulting from the wage increases, but is required to pass the remainder through to the frontline workforce.

- **Rather than increasing wages for all, can we add extra workers which will show an increase in our total wages paid out?**

No. The provider may not utilize the funds to simply hire more staff, but must use the funds to pay staff more. Audit processes will look beyond total wage expenditures, recognizing that service volumes may change. The goal is to ensure that for specified CHOICES and ECF CHOICES HCBS provided, the frontline workforce delivering the services has directly benefited from these increased funds.

- **Considering the rate increases for AC and PC are going to one rate, how do providers decide what the amount is we should increase employees? The basic question is how do we calculate what our rate increases are, so we know what we have to give to employees?**

The new rates are expected to account for an hourly wage of at least $12.50 per hour for frontline staff. Note, however, that for providers who have already been paying higher than average wages, a provider may need to raise wages above $12.50 per hour (or offer recurring retention bonuses, performance bonuses, mileage allowances, etc.) to ensure that the combination of wage increases and other investments into the wages of the frontline staff account for all of the funding which must be passed through to the direct support workforce.

- **Is the requirement that the provider must provide a 1 to 1 ratio of payroll/wage increase to rate/reimbursement increase with a wage factor applied to account for provider related costs such as taxes?**

*The expectation is that **all** of the funding provided through the rate increases is passed through to the frontline staff, except for the wage factor (16.7%) which the provider may keep offsetting increase provider taxes, etc.*

- **Are enhanced benefits (health insurance, PTO, 401k) considered part of the payroll/wage increase that the funds could be used for per guidelines?**

If a provider is already paying $12.50/hour, the provider may explore how the funds can be invested into the wages of frontline staff—such as retention bonuses, performance bonuses, mileage allowances, etc. provided that these are recurring (i.e., will occur on an annual basis to ensure that all of the funding is passed through to the direct support workforce), and that the combination of wage increases and other investments into the wages of the frontline staff account for all of the funding which must be passed through to the direct support workforce. The provider may not simply retain these funds, regardless of the current wage paid to frontline staff. While permissible, please note that these other mechanisms may increase the complexity of audit processes to ensure the funding has been passed through as intended.

- **In rural areas we want to pay $10/hr. and in metros pay $15/hr. Are you saying we can't do this?**

TennCare is not prescribing a specific wage for frontline staff. However, the rate increases are expected to account for a wage of at least $12.50 per hour. A provider may elect to apply geographic rate differentials, or other variances in their wage structure. Please note that this should be carefully documented, as it may increase the complexity of audit processes to ensure that the funding is used for its intended purpose.

- **Does giving a mileage allowance count toward the wage increase?**

Yes, if a provider is already paying $12.50/hour, the provider may explore how the funds can be invested into the wages of frontline staff—such as retention bonuses, performance bonuses, mileage allowances, etc. provided that these are recurring (i.e., will occur on an annual basis to ensure that all of the funding is passed through to the direct support workforce), and that the combination of wage increases and other investments into the wages of the frontline staff account for all of the funding which must be passed through to the direct support workforce. Again, this may increase the complexity of audit processes to ensure that the funding has been passed through as intended.

- **When do we find out the amount of the back pay and when would we receive it?**

Rate increase amounts have been shared with providers and MCOs by TennCare and have been configured in MCO claims systems. Providers were requested to submit their signed attestations in the PDMS database by November 15, 2021. TennCare has provided the names of providers submitting an attestation form to the MCOs who will then make qualifying adjustments to claims in accordance with the Enhanced FMAP Protocol. Claims processed after December 6, 2021 will reflect the new rates, retro rate adjustments will process by Feb 4, 2022- applicable only to providers who sign the attestation by November 15, 2021. Once the claim adjusts, a new remittance advice will be issued which will reflect their payment. Providers may utilize the new rate amounts to project the amount of adjustments forthcoming, as well as the broader revenue impact of these increases in order to develop their plans.

- **In addition, do all employees receive the back pay and how long do we have to expend the back paid funds?**

The memos issued provide that wage increases are retroactively effective as of July 1, 2021, may be paid as a one-time retention bonus for the period, or are otherwise accounted for in the updated wages paid to staff, with new hourly wages effective prospectively beginning as soon as possible, but no later than December 6, 2022.

- **Once the MCO's begin the back pay on the claims, will they be broken down according to the individuals or will it be one lump sum?**

Each impacted claim will be adjusted to apply the rate increases as appropriate.

- **If we increased rates, during April, May, or July for example, in hopes of these changes going live in July. Does that meet the requirements for an increase?**

Wage increases implemented for CHOICES and ECF CHOICES staff on or after 7/1/21 may be taken into account in the provider's pass-through of funds for frontline wage increases. The FMAP funding was not announced until mid-May, TennCare's plan was not posted until July 12, 2021, and initial approval was not received until August (with conditional approval to begin implementation coming in late September). Any wage increases made prior to that time could not have taken these funds into consideration. However, if a provider delivering services in CHOICES and/or ECF CHOICES AND the Section 1915(c) waivers made uniform increases in staff wages on or after April 29, 2021 (the date the FY 21-22 Appropriations Act was passed) to increase the hourly wages of ALL staff to $12.50 based on the appropriation for increases in staff wages in the 1915(c) waivers, then the portion of the increase applicable to CHOICES and/or ECF CHOICES services may also be considered in the agency's plan for ARP Enhanced HCBS FMAP funds. (The portion attributable to 1915(c) services cannot, as it was funded by the General Assembly appropriation). The agency must ensure that ALL *of the Enhanced HCBS FMAP funding is passed through to the direct support workforce in CHOICES and ECF CHOICES, as applicable, through wage increases and other investments into the wages of frontline staff.*

- **Do the raises need to be across the board base pay, or can it be performance based and average?**

*TennCare is not prescribing **how** the funds are passed through to the frontline workforce, just that they **must** be passed through in order to be eligible for the rate increase. Pay increases may be performance based, and not uniform. The provider's plan should clearly articulate all of the funding will be passed through (except for the wage factor to cover provider taxes and related expenses). Audit processes will validate that the appropriate level of funding was passed through for its intended purpose.*

- **If we increase the pay aide pay, how do we go back to less pay for the aides? As of today, all the aides want a minimum of $15/hr.**

We have already requested recurring funding for this item, and while we cannot assure the outcome of the legislative budget process, we expect (and are certainly hopeful) that these important investments continue. If funded, ARP funds will be used to "buy back" the state's share for FY 23 and part of FY 24 (until the ARP funding ends). Shared savings from the TennCare III demonstration are another potential funding source for these recurring funds.

- **What about Family Model Caregivers as they are not wage earners but contracted employees? What percentage should they receive?**

The funds are to be passed through to the family model caregivers—and any other frontline staff they may employ. This is true regardless of employee versus contractor status.

- **I uploaded the attestation in PDMS, when should a provider start using the new billing rates?**

If uploaded by 11/15, December 6 is date MCOs should begin reimbursing at the new rate. For forms submitted after that date, MCOs will be prepared to apply new rates within 3 weeks of notification that the attestation is complete. These notifications occur on a weekly basis. There will not be modifications to the MCO provider agreements.

- **Isn't billing done thru Sandata/EVV? Would it automatically update the rate of reimbursement?**

*The rates will be updated in EVV for the services that must be billed via the EVV system once a provider has completed the attestation of compliance. Eligible providers are **not** required to resubmit claims back to 7/1/21 in order to receive the retroactive rate increase for EVV or non-EVV claims.*

- **We participate in Options and VA, the rate increase for us is only required for Choices? Correct?**

Yes, these rate increases are specific to workers in CHOICES and ECF CHOICES programs.

- **For the CHOICES providers, are the reimbursement rate increases only applicable through March 31st of 2022?**

*No, the rate increases for CHOICES and ECF CHOICES are applicable through March 31, **2024** and we anticipate, but cannot guarantee, recurring funding after that date*

- **Where can I get rules about 1915(c) pay scale?**

The 1915(c) rates are available online through DIDD's website under Provider Resources and then Waiver Information. https://www.tn.gov/didd/providers.html (https://www.dropbox.com/s/esify4jqtbfm5fc/Fiscal%20Year%202022%20Services%20with%207.1.2021%20DSP%20Rate%20Increases%20and%20New%20Services%20Beginning%209.1.2021.pdf?dl=0) Any applicable rules can be found through the Secretary of State's website. (https://publications.tnsosfiles.com/rules/0465/0465-01/0465-01-02.20200105.pdf)

- **With the price spike due to inflation will there be a rate increase in the near future just directed for the provider to benefit?**

These funds are targeted to address the most pressing need identified by stakeholders, including providers. We expect, however, that by increasing the wages of the frontline staff, a provider may experience significant improvements in retention (and reductions in turnover) as well as reductions in overtime related to workforce shortages. Because there are significant opportunities for savings associated with these impacts, these funds could be used by providers to also offset other costs.

- **Do we assume correctly a provider will receive the rate increase in our bill rates and would be subject to recoupment if provider failed to invest the funds into payroll/wages?**

Yes, that is correct.

- **The wage and or benefit increases that agencies will give will apply for all staff some of whom don't provide services to CHOICES clients. Will those wages and benefits for staff that don't historically provide care to CHOICES clients be counted toward the agencies spend?**

No, this funding is specifically intended to increase the wages of the frontline HCBS workforce in CHOICES and ECF CHOICES. Only funds attributable to the frontline staff for these services will be counted.

- **The retroactive reimbursement back to July states that staff are to be paid no later than December 6, 2022 or otherwise accounted for in the updated wages paid to staff with new hourly wages effective beginning as soon as possible. We understand we can pay a bonus to staff for services from July until the wage/benefit increase went into effect. Does, "or otherwise accounted for in the updated wages paid to staff with new hourly wages," mean a provider could use the dollars earned between July 2021 and the wage increase going into effect anytime between now and 2024?**

No, the funds must be passed through to the frontline HCBS workforce now in order to be eligible for the funds. While a provider may include bonuses, etc., as part of their plan, the plan must provide for immediate investments (i.e., the passing through of the funds to the workforce).

- **Since the rate for personal care and attendant care are being equalized, do you intend to eliminate one or the other service type now or in the future to streamline scheduling and Improve EVV compliance?**

Yes, pursuant to processes set forth for the TennCare III demonstration. Providers will be given additional information as these changes are made.

- **Is a more specific list of compliance requirements going to be sent out before this starts? In addition, is a more specific requirement list of audit documentation and timelines going to be available before this begins?**

The protocols outline the specific eligibility requirements for the funding. As detailed in the prior FAQ, providers need to develop a plan by which they intend to distribute the enhanced FMAP funding to the intended recipients (direct care workforce) and have that plan on file for review upon request. Once developed, providers are encouraged to be prepared to provide validating documentation related specifically to their distribution of funds to the intended demographic as articulated in that plan. The plan must provide for recurring increases to be passed on to staff. Retention bonuses, performance bonuses, mileage allowances, etc. may be utilized provided that these are recurring (i.e., will occur on an annual basis to ensure that all of the funding is passed through to the direct support workforce), and that the combination of wage increases and other investments into the wages of the frontline staff account for all of the funding which must be passed through to the direct support workforce. While mechanisms beyond wage increase are permissible, they may increase the complexity of audit processes to validate that funds have been passed through as required. One-time bonuses, etc., will not be sufficient, in light of the fact that these investments are guaranteed to continue through 3/31/24.

- **Who is making sure providers are paying the workers the higher rates?**

TennCare has implemented robust processes to ensure providers are using the wage Increase funding for its intended purpose—to pay higher wages to their frontline staff. Across all HCBS for which rates were increased, the provider must be able to document how the higher rates were used as intended.

Providers will be required to sign an attestation of compliance in order to qualify for rate increases. A provider that does not complete the attestation or comply with the conditions of payment is not eligible for the increased rates.

TennCare will oversee audit processes to ensure that payments are made appropriately, including (but not limited to) review of provider payroll records, claims, and other documents. Payments are subject to audit and recoupment (and review for potential False Claims Act violations) if it is determined that conditions of payment were not met, i.e., that funding was not used for its intended purpose.

Provider Referral Incentives

- **Why is the referral incentive limited to residential, personal care, individual employment supports and/or specified services to increase independence and integration?**

Residential, personal care, individual employment supports and/or specified services to increase independence and integration are "core" benefits upon which the majority of program participants

rely and which significantly drive important program outcomes. Each uses a critical frontline workforce that is facing shortages. Because these services are in greater demand and potentially have a more significant impact, they have been prioritized for these payments.

- **How long will it take for the provider to be paid the "Initiation of New Services" payment, once new services have been initiated for the member?**

MCOs will proactively identify providers who are eligible for the ongoing referral and/or continuity payments. MCOs will pay providers in a timely and efficient manner, once the provider has submitted all required documentation (attestation, claims, etc.). Providers with signed attestations will receive authorizations from MCO for eligible core services and can immediately submit claims for processing.

- **How will providers know, once the 90% threshold has been met for the "Continuity of Care" payment? Is there a way for the provider to track this?**

For many services, the agency's Electronic Visit Verification (EVV) System can be used to track the provision of services and the 90% threshold. For purposes of the 90% threshold, only missed visits reduce the percentage. EVV services will be monitored through EVV systems (PA, AC, PC, IBFCTSS and SHC) and non-EVV services (CLS, CLS FM, IBCTSS, CISS, Employment, and ILST) will be tracked based on the plan and documentation from Coordinators and providers. Providers must ensure their records support the continued provision of services prior to billing and accepting the incentive payment.

- **Can providers receive multiple "Continuity of Care" payments for the same service and member?**

*In general, only one referral incentive shall be provided per member per service **type** (residential, personal care, individual employment or independence/integration).*

- **If a member has been with a provider previously, but has recently come back to that agency, are they eligible to receive the "Initiation of New Services" payment?**

Generally no.

- **In order to properly track the "Continuity of Care" payments, what would be the exact start date of the "initiation of service"?**

The exact start date of a new service would be the date the services "actually" began for the member. Providers should track the date services began for their member, through the EVV system and/or claims process.

- **Does the member/family receive any part of this Referral Incentive payment?**

No, the Provider Referral Incentive Payment is for the provider. One of the greatest challenges HCBS providers face in increasing their capacity to provide supports to additional people is the up-front investment involved in screening, hiring, training, and retaining new staff. In that regard, the payment of a new referral incentive for specified types of HCBS could help to offset these up-front costs more quickly, and greatly enhance providers' capacity to prepare to serve additional program

participants. The benefit to the family and person supported is to have access to a greater number of providers to choose from and to receive services quickly upon request.

- **If the actual number of HCBS the member wants to receive is fewer than the number of hours approved in their PCSP, would the provider still be in compliance with the Incentive Program/FMAP funding? For example, we often get referred ECF CHOICES Clients who are approved for more hours than they can complete in a week. Many of our autistic adult clients might already be working at a job or they are in college or in school. Therefore, their available hours are limited, but they still need ECF Service. For example, we might get referred a client who has a PCSP that says they are eligible for 20 hours. But they may only be available to meet with our service providers to work on their goals for 10 hours per week. Yet during those 10 hours, they are gaining skills and making progress towards all of their goals.**

*Compliance percentages take into account gaps in care that are initiated **by the member** (or family) versus **by the provider**—due to availability of staffing, etc. The expectation that 90% of approved services are delivered excludes consideration of gaps in care based on member (or family) preferences or availability*.

- **Will assisted living facilities receive the referral bonus for taking new residents?**

Yes, if they meet the criteria outlined in the protocol. See the Provider Referral Incentive Protocol here:
https://www.tn.gov/content/dam/tn/tenncare/documents/ProviderReferralIncentiveProtocol11022021.pdf

- **The referral bonus/incentive: The date is from 4/1/21. Does that mean we are paid a $500 bonus for each new client since 4/1 and additional $500 after providing services 6 months since start date? If so, what is the process for requesting this funding?**

Providers who have accepted new referrals for services since April 1, 2021 may be eligible for retroactive incentive payments. Providers may be eligible for "Initiation of New Services" payment for new services initiated which meet the criteria set forth in the protocol since April 1, 2021. If those services also meet the criteria for the "Continuity of Care" payment, providers may also be eligible for this additional payment.

Each MCO has historical data for all members that received services initiated on or after 4/1/2021, and therefore, will not require providers to submit a list of members. For all services initiated on or after this date which are identified as an eligible service, the MCOs will distribute an authorization for those services with the applicable services, dates, members, and HCPCS modifier combination. Providers will be able to submit the authorization as they submit claims today to receive $500 for "Initiation of New Services" and for "Continuity of Care," as applicable.

- **Should we request the $500 at the start of every new client and follow back up after 6 months for the additional $500?**

See above. When a provider continues to support the same member providing continuity of care for at least 6 months, with no interruption of services and 90% or greater compliance with missed visits during at least-6 months, MCOs will send a 2nd authorization for the provider to submit a claim as you do today.

- **Group 7 & 8 is not included on the rate increases or referral incentives. Is there something that will be reconsidered?**

No. These rates were more recently established and have previously been adjusted (not the amount, but the duration of various rate tiers).

- **Is the $500 referral bonus incentive to be used for general expenses or is the way these funds are spent also regulated?**

*TennCare is not prescribing how the referral incentive payments are used and will not be auditing their use. The referral incentive funds are **intended** to help offset provider costs related to increased staff capacity to deliver additional HCBS, e.g., pre-service training, background checks, etc. Funds may be used by the provider to offer recruitment and/or retention bonuses to its frontline staff—in order to help ensure both the sufficiency and stability of the frontline workforce and the return on investment.*

- **For the $500 referral bonus, do you get the referral if the resident already resides in your community and converted to CHOICES during the period or is it only for a new elderly individual moving into the community?**

The new referral incentive is not based on the locale or community where the person lives, but rather the initiation of new services (specifically a new service type) in the person's PCSP. This could be a member newly enrolled in a program, or who is beginning to receive a new type of service.

Division of TennCare

Department of Intellectual & Developmental Disabilities

You may qualify for extra services for a limited time!

We have exciting news about your services in the 1915(c) waivers operated by DIDD!

TennCare has extra funds from the federal government. It is part of COVID relief, so the funds only last for a while.

TennCare and DIDD asked for input about how to use these funds and wrote a plan. You can see that plan at https://www.tn.gov/tenncare/long-term-services-supports/enhanced-hcbs-fmap.html.

The plan is now approved. It includes extra services that you may qualify to receive. These extra services are only available for a limited time.

Extra help for your family caregiver:

Family Caregiver Supports are certain services you may qualify to get more of for a limited time. In a 1915(c) Waiver, these services are:

- Respite
- Specialized Medical Equipment; Supplies, and Assistive Technology
- Enabling Technology
- Environmental Accessibility Modifications

If you qualify, you can use up to $3,000 more of services in these groups from now until March 31, 2024. You can choose to get more of only one service or multiple services. No matter how many services you choose, you can only use up to $3,000 extra of all the services **combined**. These are **extra services**—this means you can go above the benefit limits and your annual cost cap if you need them.

Qualifying for these extra services:

To qualify for extra Family Caregiver Support, you must be enrolled in one of the 1915(c) waiver programs as of July 12, 2021, **AND** one of these things must be true. You must:

- Live with family members who routinely provide unpaid support and assistance.

OR

- If you don't live with family members, you have unpaid family caregivers who routinely provide unpaid support and assistance for you.

You don't qualify for these services if you receive any kind of residential service or if you don't have unpaid family caregivers.

Are you interested in learning more about these services? You can call your Independent Support Coordinator (ISC) or DIDD Case Manager for more information.

What if you have questions?

You can reach out to DIDD or call the LTSS help desk at **877-224-0219.**

Do you need help with this letter because you have a health problem, learning problem or a disability? Or, do you need help in another language? If so, you have a right to get help and we can help you. See the "Do you need Special Help" page with this letter. Or call **TennCare Connect** for free at **855-259-0701.**

- Do you have a mental illness and need help with this letter?

The TennCare Advocacy Program can help you. Call them for free at **800-758-1638**.

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No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you've been treated unfairly? Do you have more questions? Do you need more help? You can make a free call to **TennCare Connect** at **855-259-0701.**

Division of TennCare

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We have exciting news about your services in CHOICES!

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TennCare and DIDD asked for input about how to use these funds and wrote a plan. You can see that plan at https://www.tn.gov/tenncare/long-term-services-supports/enhanced-hcbs-fmap.html. The plan is now approved. It includes extra services that you may qualify to receive. These extra services are only available for a limited time.

Extra service for a limited time:

Enabling Technology is a new service that can help you live, work, and move around the community as safely and independently as possible. Some of the kinds of things you can get are:

- Devices to help manage your medicine
- Things to help you control your home—like doors, lights, and appliances
- Bed, chair, or motion sensors to alert someone if you fall
- Devices you can use to get live support anytime you need it (called "remote support")

There are lots more things too! If you want to explore how Enabling Technology can help you live safely and as independently as possible, tell your Care Coordinator. They will help you decide if you want to use this service. If you don't contact them, they'll talk with you about Enabling Technology when it's time to write your annual person-centered support plan (PCSP).

In CHOICES, Enabling Technology is limited to no more than $5,000 per person each year (January 1 – December 31). We only have funding for this service in CHOICES through March 31, 2024.

Extra help for your family caregiver:

Family Caregiver Supports are certain services you may qualify to get more of for a limited time. In CHOICES, these services are:

- Respite
- Adult day services
- Assistive Technology
- Enabling Technology
- Minor Home Modifications

If you qualify, you can use up to $3,000 more of services in these groups from now until March 31, 2024. You can choose to get more of only one service or multiple services. No matter how many services you choose, you can only use up to $3,000 extra of all the services **combined**. These are **extra services**—this means you can go above the benefit limits and your annual cost cap if you need them.

Qualifying for these extra services:

To qualify for extra Family Caregiver Support, you must be enrolled in CHOICES as of July 12, 2021, **AND** one of these things must be true. You must:

- Live with family members who routinely provide unpaid support and assistance.

OR

- If you don't live with family members, you have unpaid family caregivers who routinely provide unpaid support and assistance for you.

You don't qualify for these services if you receive any kind of residential service or if you don't have unpaid family caregivers.

Increased wages for direct support staff

What else are we using the extra funds for? TennCare is offering providers higher rates to increase wages for direct support staff who provide services in CHOICES. We are increasing the wages of workers hired through consumer direction too. This will help you get the quality services you need. Even though we are paying more for your services, it won't affect the services you get now, even if you go over your annual cost cap.

Are you interested in learning more about these services? You can call your Care Coordinator for more information.

What if you have questions?

You can reach out to <MCO name> at the number on the back of your card or call the LTSS help desk at **877-224-0219.**

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Division of TennCare

Department of Intellectual & Developmental Disabilities

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- Devices to help manage your medicine
- Things to help you control your home—like doors, lights, and appliances
- Bed, chair, or motion sensors to alert someone if you fall
- Devices you can use to get live support anytime you need it (called "remote support")

There are lots more things too! If you want to explore how Enabling Technology can help you live safely and as independently as possible, tell your Support Coordinator. They will help you decide if you want to use this service. If you don't contact them, they'll talk with you about Enabling Technology when it's time to write your annual person-centered support plan (PCSP).

In Employment and Community First CHOICES, the limit for Enabling Technology is combined with the limit for Assistive Technology, Specialized Medical Equipment and Supplies. You can get a total of up to $5,000 of both services **combined** each year (January 1 – December 31).

Extra help for your family caregiver:

Family Caregiver Supports are certain services you may qualify to get more of for a limited time. In Employment and Community First CHOICES, these services are:

- Respite
- Assistive technology, adaptive; equipment and supplies
- Enabling Technology
- Minor Home Modifications

If you qualify, you can use up to $3,000 more of services in these groups from now until March 31, 2024. You can choose to get more of only one service or multiple services. No matter how many services you choose, you can only use up to $3,000 extra of all the services **combined**. These are **extra services**—this means you can go above the benefit limits and your annual cost cap if you need them.

Qualifying for these extra services:

To qualify for extra Family Caregiver Support, you must be enrolled in Employment and Community First CHOICES as of July 12, 2021, AND one of these things must be true. You must:

- Live with family members who routinely provide unpaid support and assistance.

OR

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What else are we using the extra funds for? TennCare is offering providers higher rates to increase wages for direct support staff who provide services in Employment and Community First CHOICES. We are increasing the wages of workers hired through consumer direction too. This will help you get the quality services you need. Even though we are paying more for your services, it won't affect the services you get now, even if you go over your annual cost cap.

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