Wellpoint • Tennessee | TennCare CHOICES

Provider Manual Supplement

Wellpoint℠

866-840-4991
provider.wellpoint.com/tn

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Wellpoint retains the right to add to, delete from and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Wellpoint as proprietary and confidential.

No person, on the grounds of handicap and/or disability, age, race, color, religion, sex, or 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.

Please note: Material in this provider manual is subject to change. Please go to **provider.wellpoint.com/tn/** for the most up-to-date information.

We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call 833-731-2154. Information about the civil rights laws can be found at tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

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Introduction

This supplement to the Wellpoint Tennessee, Inc. provider manual specifically discusses the TennCare Managed Long-Term Services & Supports (MLTSS) CHOICES program (CHOICES). For information specifically on Medicaid services, please refer to the general Wellpoint provider manual. All requirements from the general Wellpoint provider manual apply to the CHOICES program.

TennCare CHOICES Long-Term Services & Supports

The TennCare CHOICES (CHOICES) Managed Long-Term Services & Supports (MLTSS) program is a Medicaid LTSS system redesign initiative that integrates LTSS services, including nursing facility services and home and community-based services (HCBS) alternatives to nursing facility care, into the existing TennCare managed care delivery system.

CHOICES is for adults (age 21 and older) with a physical disability and seniors (age 65 and older). CHOICES offers services to help a person live in their own home or in the community. These services are called Home and Community Based Services or HCBS. These services can be provided in the home, on the job, or in the community to assist with daily living activities and allow people to work and be actively involved in their local community. CHOICES also provides care in a nursing home if this is needed.

The primary goals of CHOICES are to:

- Provide streamlined, timely access to LTSS services.
- Expand access to and utilization of cost-effective HCBS alternatives to nursing facility care.
- Serve more people with existing LTSS funds.
- Increase HCBS options.
- Improve coordination of all Medicaid (acute, behavioral and LTSS) services.
- Rebalance LTSS spending (that is, funding spent on institutional versus HCBS).

Quick Reference Information

Please call Provider Services at **833-731-2154** 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.

Available Contact Information

Providers can call Provider Services at **833-731-2154** for:

- A Provider Services representative — available Monday through Friday, 8 a.m. to 5 p.m. Central time.
    - Speak to a live agent about precertification/notification, health plan network information, individual eligibility, claims information and inquiries.
- The automated Provider Inquiry Line (IVR) — 24 hours a day, 7 days a week.
    - Check claims status and eligibility.
    - Request interpreter services.

Enrolled members can call **866-840-4991** for:

- Member services — available Monday through Friday, 8 a.m. to 5:30 p.m. CT
- The Nurse HelpLine:
  - Clinical services are available 24 hours a day, 7 days a week.
  - We can help coordinate behavioral health care needs.

Provider Services at the National Contact Center Fax: **800-964-3627**

Provider Relations Department: **833-731-2154**

Behavioral Health Inpatient Services Fax: **800-877-5211**

Behavioral Health Outpatient Services Fax: **866-920-6006**

Electronic Data Interchange (EDI) Hotline: **800-590-5745**

Electronic Visit Verification (EVV) Help Desk: **855-329-2116**

Family Assistance Service Center: **615-743-2000**

TennCare Fraud and Abuse Hotline: **800-433-3982**

TennCare Phone Number: **800-852-2683** toll free or **615-741-6669** (Nashville local)

Availity: **800-AVAILITY (800-282-4548)**

EVV Assistance email box: tn1ltcevvcs@wellpoint.com

LTC Authorization email box: ltcprovreq@wellpoint.com

Enhanced HCBS – FMAP Communication:
tn.gov/tenncare/long-term-services-supports/enhanced-hcbs-fmap.html

Individual Eligibility

TennCare enrollees will be enrolled by TennCare into CHOICES if the enrollee meets the categorical and financial eligibility criteria for Groups 1, 2 or 3:

- **Group 1:** All persons who receive Medicaid-reimbursed long-term nursing facility care.
- **Group 2:** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the nursing facility level of care, qualify either as SSI recipients or as members of the CHOICES-like HCBS Group, and need and receive HCBS as an alternative to nursing facility care. **Group 3**: Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI recipients or members of the CHOICES At-Risk Demonstration Group, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group as described in TennCare rules and regulations.

Individual Enrollment

Individuals enrolled in TennCare will be enrolled by TennCare into CHOICES if the following conditions are met:

- TennCare or its designee determines if the individual meets the categorical and financial eligibility criteria for Group 1, 2 or 3.
- For Groups 1 and 2: TennCare determines if the individual meets nursing facility level of care.
- For Group 2: Wellpoint, or for new TennCare applicants, TennCare or its designee, determines if the individual's combined HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the individual.
- For Group 3: TennCare determines if the individual meets the at-risk level of care.
- For Groups 2 and 3: If there's an enrollment target, TennCare determines if the enrollment target has not been met or, for Group 2, approves the Wellpoint request to provide HCBS as a cost-effective alternative. Individuals transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

For individuals residing in a community-based residential alternative at the time of CHOICES enrollment, authorization for community-based residential alternative services will be retroactive to the individual's effective date of CHOICES enrollment.

Access and Availability

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

CHOICES Referrals

Provider selection during the assessment process is driven by the member being served. Petitioning members with the expectation of being selected as the service provider or petitioning existing members who receive CHOICES services to change CHOICES providers is prohibited. Additionally, communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHOICES members that should instead be referred to the person's MCO or local Area Agency on Aging and Disability (AAAD), as applicable, is prohibited.

Electronic Visit Verification System

The Electronic Visit Verification (EVV) system is an automated electronic system used to monitor member receipt and utilization of CHOICES HCBS services. Our current EVV vendor is CareBridge. Provider staff arrival and departure are captured through the use of a static GPS device in EVV.

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

To use the EVV system, providers check in using a GPS tablet device at the member's home promptly on arrival. The provider's employee may download the Wellpoint EVV application to their own Android or Apple smartphone at no charge, which can be used for checking in and out of a visit if the member's tablet is not available. This confirms the identity of the member provider/staff worker as well as the arrival time and location. If neither of these options are available, the caregiver can utilize the member's phone to check in. At the end of the shift or assignment (and prior to leaving the member's home), the provider/staff worker will check out using the tablet device or the same method in which the check in occurred, logging the departure time and completing a brief survey. This survey will only be available via the tablet method for checking out. If a provider/staff worker fails to check in at the appropriate time, the EVV system will alert Wellpoint and steps will be taken to ensure the member receives the appropriate care at the appropriate time.

At a minimum, providers should have at least one full-time staff person devoted to EVV system monitoring, including after hours and weekends, if a member is scheduled to receive care, and two staff persons fully trained and knowledgeable of the EVV system and its functionality. Use of this system is compulsory by providers administering HCBS services to Wellpoint members.

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

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

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

- Log the arrival and departure of the provider/staff worker
- Verify that services are being delivered at the correct location (for example, the member's home) and at the appropriate time
- Verify the identity of the provider/staff worker providing the service to the member
- Match the services provided to a member with the services authorized in the person-centered support plan
- Ensure adherence to the established schedule of services
- Ensure the provider/staff worker delivering the service is authorized to deliver such services

- Establish a schedule of service delivery with as much flexibility and/or specificity within the authorization and program rules as the member wants and needs. Identify the time each service is needed including the amount, frequency, duration and scope of each service
- Provide notification to EVV team if a worker does not arrive as scheduled or otherwise deviates from the authorized schedule; this ensures service gaps and the reason service was not provided as scheduled are identified and addressed immediately, and backup plans are implemented as appropriate
- Keep the late/missed visit (LMV) dashboard up-to-date and accurate. Visibility of LMV entries is lost after seven calendar days from the dashboard. This information is used for a state report and must be accurate.
- Log the delivery of home-delivered meals including the member's name, time delivered and, if applicable, the reason a meal was not delivered
- Generate claims for submission to Wellpoint
- Capture worker/member surveys
- Manage all tablets assigned to members under their care

Wellpoint requires contracted providers to use the EVV system for applicable services. Contracted providers must have at least two staff persons fully trained on the EVV system that can train caregivers on using the device in the member's home. An additional expectation is that at least one staff person with the contracted provider is dedicated to monitoring caregiver activity to ensure caregivers are in the member's home providing services at the scheduled time agreed upon when the referral was accepted.

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

Performance Metrics for Provider Compliance

Staffed Appointments

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

Example:

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

Manually Confirmed Visits

A manual confirmation should be submitted by the provider in order to be paid for the following scenarios:

- Late visits
- Missed visits
- Visits in which the length deviates from authorization
- No authorization on file for visit
- Split visits
- More than one worker per visit
- When no check-in/out is recorded for the member.

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

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

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

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

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

Example:

100 total appointments
Five manually confirmed visits
95 GPS/telephony confirmed visits
95/100 = 95 percent compliance score

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

Missed Visit Reason Code/Resolution Status
It is the provider's responsibility to maintain the appropriate selection of reason codes/resolution statuses for all missed visits via the EVV system dashboard. This will be monitored through results from missed visits without reason codes/resolution statuses populated in an appropriate or timely manner. Providers have access to enter reason codes/resolution statuses up to seven days after the appointment date. Failure to submit a reason code/resolution status will result in an automated blank submission and will be added to the numerator in the missed visit calculation. Scores will be calculated as the total missed visits with reason codes/resolution statuses divided by the total number missed visits as applicable.

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

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

Late Missed Visits (LMV) reports

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

Wellpoint Tennessee, Inc. sends a report to each agency with a response due date. The provider agency populates the report with the following information and returns the report to Wellpoint by the specified due date:

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

- Confirmation whether the member's backup plan was initiated
- Brief explanation of the follow-up actions taken by the provider to prevent future missed visits

Best practices for providers:

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

Tips for completing the LMV report:

- Ensure that the provider agency's email address for LMV data is correct. Updated email addresses can be sent to the EVV mailbox at tn1ltcevvcs@anthem.com.
- Do not make changes to prefilled cells.
- Do not change the format of the document. The document should be returned in Excel format via email.
- Do not send the Excel file as a secure email.
- Responses must provide accurate information as well as specific details regarding the appointment. Generic answers for each member are not acceptable.
- Check both the late and missed visit tabs within the request.
- Responses must be professional, free of spelling errors, and grammatically correct.

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

Measuring Compliance Criteria

Wellpoint monitors the following criteria to determine provider agency compliance:

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

Effective January 1, 2020, in accordance with the *TennCare Contractor Risk Agreement* (*TennCare CRA*), changes were made to the manner in which Liquidated Damages (LD) will be assessed. Liquidated Damages will be assessed to the MCO based on provider and MCO driven late visits, missed visits and visits that are manually-confirmed. Providers must meet at least 90% compliance for late visits, missed visits, check-ins and check-outs. LDs will be assessed at $5,000 and up per provider per month for EACH noncompliant metric. If a provider agency is deemed noncompliant due to late, missed and manually confirmed visits the MCO may opt to pass through liquidated damages that are assessed as stated in your provider manual supplement and agreements.

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

Effective January 1, 2020, in accordance with the *TennCare CRA*, updates were made to the following LDs based on the percentage of noncompliance with **each** metric (provider-initiated late visits, missed visits, manual confirmations):

- $5,000 per month that 11-15% of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS
- $10,000 per month that 16-20% of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS
- $15,000 per month that 21-25% of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS
- $20,000 per month that 26-30% of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS
- $25,000 per month that 31% or more of visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), by specified HCBS

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

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

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

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

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

LTSS Benefits for Individuals Enrolled in CHOICES

In addition to the physical and behavioral health benefits listed in the Wellpoint Medicaid provider manual, we provide LTSS services (including HCBS and nursing facility care) to members who have been enrolled into CHOICES by TennCare with the exception of Immediate Eligibility groups.

The following Long-Term Services and Support Benefits are available to members enrolled in CHOICES, per Group, when the services have been determined medically necessary through the Wellpoint assessment process and documented in the member's authorized initial person-centered support plan and comprehensive assessment.

Service and Benefit Limit	**Group 1**	**Group 2 Full Medicaid Eligibility**	**Group 3**
Nursing facility care	X	Short term only (up to 90 days)	Short term only (up to 90 days)
Community-based residential alternatives		X	X (Specified CBRA services and levels of reimbursement only. See below)*
Personal care visits (up to two visits per day at intervals of no less than 4 hours between visits)		X	X
Attendant care (up to 1,080 hours per calendar year, up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)		X	X
Home-delivered meals (up to one meal per day)		X	X
Personal emergency response systems (PERS) one unit installation and (one unit per month for 12 months a year)		X	X
Adult day care (up to 2,080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
Inpatient respite care (up to nine days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X

Service and Benefit Limit	Group 1	Group 2 Full Medicaid Eligibility	Group 3
Enabling technology (limited to $5,000 per calendar year and is available only through March 31, 2025)		X	X
Minor home modifications (up to $6,000 per project, $10,000 per calendar year and $20,000 per lifetime)		X	X
Pest control (up to nine units per calendar year)		X	X

* CBRAs for which Group 3 member are eligible include only: Assisted Care Living Facility services, Community Living Supports 1 (CLS1), and Community Living Supports-Family Model 1 (CLS-FM1)

In addition to the service limits described above, for members enrolled in CHOICES in Group 2, the total cost of HCBS, home health care and private duty nursing will not exceed the cost of providing nursing facility services to the person. For members enrolled in CHOICES in Group 3, the total cost of HCBS, excluding minor home modifications, will not exceed the expenditure cap.

A CHOICES member in Group 2 shall not be disenrolled or required to experience a reduction in the amount of services currently being provided as a result of State directed increases in the rate of payment for such services, including rate increases targeted to increase wages for direct support professionals in order to help providers recruit and retain staff. If an increase in the rate of payment for service(s) would result in a person's individual cost neutrality cap being exceeded, the person shall not be required to reduce the amount of previously authorized services. The State may establish a methodology that would disregard some or all such rate increases in the application of the individual cost limit. Except as provided in that methodology, all new or additional services will be subject to the individual cost limit.

Notwithstanding any other requirements of this Contract, CHOICES Groups 2 and 3 members enrolled as of July 12, 2021, will be eligible to exceed their Expenditure Cap or their Individual Cost Neutrality Cap, as applicable, in order to receive a one-time increase of up to $3,000 across the following services:

- Respite;
- Adult Day Care Services;
- Assistive Technology;
- Enabling Technology; and
- Minor Home Modifications.

The $3,000 is a one-time increase that may be utilized anytime between November 2, 2021, and March 31, 2025. A member may elect to receive additional units of one service or multiple services; however, the overall limitation on additional services is $3,000 per person. This assistance is provided in addition to existing service limitations and without regard for the expenditure cap or individual cost neutrality test specified in the approved waiver.
To qualify for this additional assistance the individual must be enrolled in the CHOICES program as of July 12, 2021, living with family members who routinely provide unpaid support and assistance; or if

the individual does not live with family members, must have unpaid family caregivers who routinely provide unpaid support and assistance. The person may not be receiving residential supports.

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

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

Increases in the expenditure cap or individual cost neutrality cap effective July 1, 2021, are not intended to provide for additional benefits, but rather to accommodate targeted rate increases in CHOICES that have a direct care component as provided in Tennessee's conditionally approved Initial HCBS Spending Plan. These adjustments will ensure that individuals in each of these benefit groups continue to have access to their currently approved HCBS.

Members enrolled in CHOICES may choose to participate in consumer direction of HCBS and, at a minimum, hire, fire and supervise workers' specific HCBS functions.

Wellpoint may submit to TennCare a request to no longer provide LTSS services to a member due to concerns regarding the ability to safely and effectively care for the person in the community and/or to ensure the member's health, safety and welfare. This may include the following situations:

- A member in Group 2 or 3 for whom Wellpoint has determined cannot safely and effectively meet the person's needs at a cost that is less than the member's cost neutrality cap and who has declined to transition to a nursing facility.
- A member in Group 2 or 3 who repeatedly refuses to allow a care coordinator entrance into their place of residence.
- A member in Group 2 or 3 who refuses to receive critical HCBS services as identified through a needs assessment and documented in the member's person centered support plan.
- A member in Group 1 who fails to pay their patient liability, and Wellpoint is unable to find a nursing facility willing to provide services to the member.

The request by Wellpoint to no longer provide LTSS services to a member will include documentation as specified by TennCare. The state will make any and all determinations regarding whether Wellpoint may discontinue providing LTSS services to a member, disenrollment from CHOICES and, as applicable, termination from TennCare.

Cost-Sharing and Patient Liability

Providers cannot 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 in accordance with TennCare rules and regulations, including holding members liable for debt due to insolvency of Wellpoint or nonpayment by the state to Wellpoint. Further, providers shall not charge members for missed appointments.

Patient Liability
TennCare will notify Wellpoint of any applicable patient liability amounts for members enrolled in CHOICES via the eligibility/enrollment file. Wellpoint will delegate collection of patient liability to the facility and will pay the facility net of the applicable patient liability amount for members in Group 1 and members who are receiving services in a community-based residential alternative. Members enrolled in Group 2 or Group 3 receiving other HCBS services will have patient liability due to the MCO.

In accordance with the involuntary discharge process, including notice and appeal, a facility may refuse to continue providing services to a person who fails to pay their patient liability and for whom the facility can demonstrate to Wellpoint that it has made a good faith effort to collect payment.

If Wellpoint is notified that a facility is considering discharging a member, Wellpoint will work to find an alternate facility willing to serve the person and document its efforts in the member's files.
If we are unable to find an alternate facility willing to serve the member, we will determine if we can safely and effectively serve the person in the community and within the cost neutrality cap. If we can, the member will be offered a choice of HCBS. If the person chooses HCBS and the person is currently enrolled in Group 1, we will forward all relevant information to TennCare for a decision regarding enrollment in Group 2.

If we are unable to find an alternate facility willing to serve the member, and we determine we cannot safely and effectively serve the member in the community and within the cost neutrality cap for members in Group 2 or the expenditure cap for members in Group 3, or the member declines to enroll in Group 2 or TennCare denies enrollment in Group 2 (for those members enrolled in Group 1), we may request to no longer provide LTSS services to the person.

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

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

Providers may seek payment from a member only in the following situations:

- If the services are not covered services and, prior to providing the services, the provider informed the member the services were not covered; the provider will inform the member of the noncovered service and have the member acknowledge the information; if the person still requests the service, the provider will obtain such acknowledgment in writing prior to rendering the service; regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Wellpoint for the service that has been provided, the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.

- If the member's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively; regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Wellpoint for the service, the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.
- If the member's TennCare eligibility is pending at the time services are provided; however, all monies collected, except applicable TennCare cost sharing or patient liability amounts, shall be refunded when a claim is submitted to Wellpoint because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established; the monies collected will be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim.
- If the services are not covered because they are in excess of a member's benefit limit and the provider complies with applicable TennCare rules and regulations.

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

Disclosure Reporting

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

Authorization/Notification Requirements

Authorization is required for all HCBS and Skilled Nursing Facility Services. Authorizations are not required for group 1 members Nursing Facility (NF) services billed by a participating provider.

To request a LTSS authorization or a change in the member's person-centered support plan, please send an email to ltcprovreq@wellpoint.com and include the following information:

- Provider name/Wellpoint Provider ID

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

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

In the event of emergencies (for example, tornados, earthquakes, floods, and public health emergencies such as a pandemic) as determined by TennCare, TennCare may direct the MCO to suspend certain policies and administrative activities such as Prior Authorizations, Record Requests, and Audits.

Workforce Development

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

Service Discontinuation

For service discontinuation:

- Notice is to be provided no less than 60 days prior to the proposed date of service discontinuation in writing to the member (or guardian/conservator) and the Care Coordinator.
- Provider is to obtain written approval/notification from Wellpoint.
- Provider is to cooperate with transition planning, including providing service beyond 30 days if needed and working with the new provider to ensure continuity of care.

CHOICES Provider Business Model

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

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

CHOICES Care Coordination

All members enrolled in CHOICES will be assigned a care coordinator. The member's care coordinator is the person who has primary responsibility for performance of care coordination activities for a member receiving services in CHOICES. Wellpoint uses care coordination as the continuous process of:

- Assessing a member's physical, behavioral, functional and psychosocial needs and developing the member's person-centered support plan
- Assessing risks for members enrolled in CHOICES Group 2 and Group 3 for receiving services in the community and identifying specific strategies to mitigate these risks
- Identifying and authorizing the physical health, behavioral health and LTSS services, and other social support services and assistance (for example, housing or income assistance) that are necessary to meet identified needs contained in the person-centered support plan
- Ensuring timely access to and provision, for coordinating and monitoring of physical health, behavioral health and LTSS services needed to help the member maintain or improve their physical or behavioral health status, or functional abilities and maximize independence
- Facilitating access to other social support services and assistance needed in order to ensure the member's health, safety and welfare and, as applicable, to delay or prevent the need for more expensive institutional placement

Wellpoint will provide information regarding the role of the care coordinator and will request providers and caregivers to notify a member's care 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. We will provide training to key providers and caregivers regarding the value of this communication and remind them that the member's identification card indicates if a member is enrolled in CHOICES.

Person-Centered Support Plan

As it pertains to CHOICES, the PCSP is a written plan developed by the Care Coordinator, in accordance with person-centered planning requirements set forth in federal regulation, and in TennCare policies and protocols, using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals, and 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 member's MCO and other payor sources. The person-centered planning process is directed by the member with long-term support needs 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. If the member has a guardian or conservator, the member shall lead the planning process to the maximum extent possible, and the guardian or conservator shall have a participatory role as needed and defined by the member, except as explicitly defined under State law and the order of guardianship or conservatorship. Any decisions made on the member's behalf should be made using principles of substituted judgment and supported decision-making. 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 appropriate, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth. Services in CHOICES will be authorized, provided, and reimbursed only as specified in the PCSP.

For Members in CHOICES Group 1

For members in CHOICES Group 1, the member's care coordinator/care coordination team may:

- Rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member.
- Supplement the plan of care as necessary with the development and implementation of targeted strategies to improve health, functional ability or quality of life outcomes (for example, related to Population Health services or pharmacy management) or to increase and/or maintain functional abilities.
- Request to attend care rounds in order to best support the member.
- Assess for and assist with a transition to the community if the member desires to return to a less restrictive environment.

Care coordinators will participate in the nursing facility's care planning process and advocate for the member.

The member's care coordinator/care coordination team is responsible for coordinating the member's physical health, behavioral health and LTSS needs, which will include coordinating with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic physical health or behavioral health conditions, including services covered by Wellpoint that are beyond the scope of the nursing facility services benefit.

For Members in CHOICES Groups 2 and 3
For members in CHOICES Groups 2 and 3, the care coordinator will coordinate and facilitate a care planning team that includes the member, those identified by the member who act as natural supports and the member's care coordinator. The care coordinator will include or seek input from other members, such as the member's representative or other persons authorized by the member to assist with needs assessment and care planning activities as needed.

Care coordinators will consult with the member's PCP, specialists, behavioral health providers, other providers and interdisciplinary team experts as needed when developing the person-centered support plan.

The care coordinator will verify that the decisions made by the care planning team are documented in a written, comprehensive person-centered support plan.

The person-centered support plan developed for members enrolled in CHOICES Groups 2 and 3 prior to initiation of HCBS includes:

- Gathering pertinent demographic information regarding the member, including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term-care-related information) and assisting with assessment, planning and/or implementation of health care (including long-term- care related services and supports).
- Determining care, including specific tasks and functions that will be performed by family members and other caregivers.
- Determining home health, private duty nursing and LTSS services the member will receive from other payer sources including the payer of such services.
- Determining home health and private duty nursing services that will be authorized by Wellpoint, except in the case of persons enrolled on the basis of Immediate Eligibility who will have access to services beyond the limited package of HCBS only upon determination of categorical and financial eligibility for TennCare.

HCBS that will be authorized by Wellpoint include:

- The amount, frequency, duration and scope (tasks and functions to be performed) of each service to be provided.
- The schedule of when such care is needed.

Within 30 calendar days of notice of enrollment in CHOICES, for members in CHOICES Groups 2 and 3, the plan of care will include the following additional elements:

- Description of the member's current physical and behavioral health conditions and functional status (that is, 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
- Description of the member's psychosocial needs, including any housing or financial assistance needs that could impact the member's ability to maintain a safe and healthy living environment
- Description of goals, objectives and desired health; and the functional and quality of life outcomes for the member
- Description of other services that will be provided to the member, including:
    - Covered physical and behavioral health services that will be provided by Wellpoint to help the member maintain or improve their physical or behavioral health status, or functional abilities and maximize independence
    - Other social support services and assistance needed in order to ensure the member's health, safety and welfare and, as applicable, to delay or prevent the need for more expensive institutional placement
    - Any noncovered services including services provided by other community resources, including plans to link the member to financial assistance programs, including housing, utilities and food as needed
- Relevant information from the person's treatment plan for any member receiving behavioral health services that is needed by a LTSS provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of services
- Relevant information regarding the member's physical health condition(s), including the treatment and medication regimen needed by a LTSS provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of care
- Frequency of planned care coordinator contacts needed, which will include consideration of the person's member needs and circumstances
- Additional information for members who elect consumer direction of HCBS, including whether the member requires a representative to participate in consumer direction and the specific services that will be consumer-directed
- Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol
- A disaster preparedness plan specific to the member
- The member's TennCare eligibility end date

The member's care coordinator/care coordination team will ensure that the member reviews, signs and dates the person-centered support plan, as well as any updates.

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 person-centered support plan), Wellpoint will, in the case of a new person-centered support plan, authorize and initiate services in accordance with the person-centered support plan. In the case of an annual or revised person-centered support plan, Wellpoint will ensure continuation of at least the level of services in place at the time the annual or revised person-centered support plan was developed until a resolution is reached, which may include resolution of a timely filed appeal. Wellpoint will not use the member's acceptance of services as a waiver of the member's right to dispute the person-centered support plan or as cause to stop the resolution process.

When the refusal to sign is due to the inclusion of services that the member does not want to receive, either in totality or in the amount, frequency, scope or duration of services in the person-centered support plan, the care coordinator will modify the risk agreement to note this issue, the associated risks and the measures to mitigate the risks as part of the person-centered support plan. In the event the coordinator determines the member's needs cannot be safely and effectively met in the community without receiving these services, Wellpoint may request that it no longer provide LTSS services to the member.

The member's care coordinator/care coordination team will provide a copy of the member's completed person-centered support plan, including any updates, to the member, the member's representative and the member's community-based residential alternative provider and other providers authorized to deliver care to the member, as applicable. The member's care coordinator/care coordination team will provide copies to other providers authorized to deliver care to the member upon request and will ensure that such providers who do not receive a copy of the plan of care 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 business days of completing a reassessment of a member's needs, the member's care coordinator/care coordination team will update the member's plan of care as appropriate and authorize and initiate HCBS in the updated plan of care.

The member's care coordinator will inform each person of their eligibility end date and educate the member regarding the importance of maintaining TennCare CHOICES eligibility, renewing eligibility at least once a year, and being contacted near the date of a redetermination to assist them with the process (for example, collecting appropriate documentation and completing the necessary forms).

Consumer Direction

We offer consumer direction for HCBS to all members enrolled in CHOICES Group 2 and 3 who are determined by a care coordinator through the needs assessment/reassessment process to need attendant care, personal care, in-home respite care, companion care services and/or any other service specified in TennCare rules and regulations as available for consumer direction. A service that is not specified in TennCare rules and regulations as available for consumer direction shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible 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. Self-direction of health care task is an option for members participating in consumer direction to direct and supervise a paid worker delivering eligible CHOICES HCBS in the performance of health care task that would otherwise be performed by a licensed nurse. Self-direction of health care task is not a service, but rather health care-related duties and functions. Member participation in consumer direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time, service by service, without affecting their enrollment in CHOICES.

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

Nursing Facility — Pre-Admission Screening and Resident Review

The Pre-Admission Screening and Resident Review (PASRR) process must be completed prior to admission of a member into a Medicaid-Certified Nursing Facility. A Medicaid-Certified Nursing Facility should not admit a member prior to confirmation that an appropriate PASRR has been completed. As part of the approval process for the PASRR/level-of-care for persons in PASRR population, there are times that specialized services are identified as a requirement for meeting the needs of the member while in the nursing facility, and all identified specialized services must be coordinated by Wellpoint immediately upon admission. Any specialized services that are recommended will be identified in the PASRR summary report. To the maximum extent possible, Wellpoint shall seek to ensure that specialized services are delivered by community providers (not the nursing facility) in order to establish relationships that will help facilitate exploration of community-based service delivery options, develop trust, and ensure continuity of providers and services when the person is willing and ready to transition to the community. The Wellpoint assigned care coordinator will validate when completing coordination activities that these services are in place for the member.

For additional information, please reference federal regulation *42 §483.30(e) (1) & (4) Physician Services. and – 42 §483.35 — Nursing Services* (that is, Staff competencies and skill sets). For PASRR federal regulations, please reference federal regulation 42 CFR 483.100-138.

Nursing Facility – Enhanced Respiratory Care

Nursing facilities must meet requirements prior to providing enhanced respiratory care (ERC) services to members enrolled with Wellpoint.

1. TennCare establishes ERC rates for skilled nursing facilities (SNFs) delivering ERC services according to certain criteria set forth in TennCare Rule 1200-13-01-.10(5)
2. Nursing Facilities must meet standards of care for vent weaning, chronic ventilator care and tracheal suctioning as set forth in TennCare Rule 1200-13-01-.10(5) and the service must meet medical necessity and requires an authorization from Wellpoint.
3. Vent weaning must meet medical necessity and requires an authorization from Wellpoint.
4. Chronic ventilator care must meet medical necessity, requires an approved PAE from TennCare, and requires an authorization from Wellpoint.
5. Tracheal suctioning must meet medical necessity, requires an approved PAE from TennCare and requires an authorization from Wellpoint.
6. Nursing facilities must accept TennCare members for vent weaning, chronic ventilator care and/or tracheal suctioning up to the number of approved licensed beds.

7. Wellpoint will request the ERC provider to confirm that they have licensed beds available prior to approving the authorization.
8. Nursing facilities must have the ERC rate as part of their contract prior to providing service.

Nursing Facility Level of Care Determination Requirement

Wellpoint requires that all contracted nursing facilities submit complete and accurate PAEs that satisfy all technical requirements specified by TennCare, and accurately reflect the member's current medical and functional status, including Safety Determination Requests. Wellpoint additionally requires that the nursing facility also submit all supporting documentation required in the PAE and *Safety Determination Request Form*, as applicable and required pursuant to TennCare Rules. Failure to meet this requirement can impact the contractor's reimbursement and/or ability to continue to provide services to members enrolled with Wellpoint.

Nursing Facility Diversion

The nursing facility diversion process targets the following groups for diversion activities:

- Members in CHOICES Group 1 who are waiting for placement in a nursing facility
- Members in CHOICES residing in their own homes who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services
- Members in CHOICES residing in adult care homes or other community-based residential alternative settings who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services
- Members receiving CHOICES and non-CHOICES services admitted to an inpatient hospital or inpatient rehabilitation who are not residents of a nursing facility
- Members receiving CHOICES and non-CHOICES services who are placed short-term in a nursing facility, regardless of payer source

The nursing facility diversion process will not prohibit or delay a member's access to nursing facility services when these services are medically necessary and requested by the member.

Nursing facility diversion activities involve increasing community-based support that can include CHOICES services and access to community-based residential alternatives in lieu of nursing facility placement when the member prefers to remain in the community setting.

Nursing Facility-to-Community Transition

Wellpoint identifies members who may have the ability and/or desire to transition from a nursing facility to the community. Our methods include:

- Referrals, including from the following sources:
  - Treating physician
  - Nursing facility
  - Other providers
  - Community-based organizations

    - Family
    - Self-referrals
- Identification through the care coordination process, including:
    - Assessments
    - Information gathered from nursing facility staff
    - Participation in Grand Rounds
    - Conversation/discussion with the member residing in a nursing facility who expresses interest in returning to the community to live
- Review and analysis of members identified by TennCare based on minimum data set from nursing facilities

For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, we conduct an in-facility visit with the member to determine the person's interest in and potential ability to transition to the community. In addition, we provide orientation and information to the member regarding transition activities within 14 days of the referral.

For identification by means other than referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, we conduct an in-facility visit with the member to determine whether or not the person is interested in and has the potential ability to pursue transition to the community within 90 days of such identification.

The member's care coordinator/care coordination team will document in the member's case file that transition was discussed with the person and indicate the member's wishes as well as the member's potential for transition. Wellpoint will not require a member to transition when the person expresses a desire to continue receiving nursing facility services.

If the member wishes to pursue transition to the community, within 14 days of the initial visit or within 14 days of identification through the care coordination process, the care coordinator will conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by TennCare. This assessment will include the identification of any barriers to a safe transition.

As part of the transition assessment, the care coordinator will assess for risks related to the member's transition to the community. This will include assessing for known risks, documenting those risks and developing a mitigation plan for those risks. The transition assessment is completed in collaboration with the member and/or their representative and will also involve discussions with current caregivers in the nursing facility.

The member's care coordinator/care coordination team will also make a determination regarding whether the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. The member's care coordinator/care coordination team will explain to the person the member cost neutrality cap and notification process and obtain a signed acknowledgement of understanding by the member or their representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that

would result in the inability of Wellpoint to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, Wellpoint will assist with transition to a more appropriate care delivery setting.

For those members whose transition assessment indicates that they are not candidates for transition to the community, the care coordinator will notify them in accordance with the specified transition assessment protocol. In addition, if transition is still sought, the care coordinator will work with the member to develop goals that progress the member toward the independence needed to reside in the community.

For those members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator will facilitate the development of and complete a transition plan within 14 days of the member's transition assessment.

The care coordinator will include other people such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves and such persons are willing and able to participate.

As part of transition planning, prior to the member's physical move to the community, the care coordinator will visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The care coordinator will include in the transition plan, activities and/or services needed to mitigate any perceived risks in the residence, including an increase in face-to-face visits beyond the minimum required contacts.

The transition plan will address all services necessary to safely transition the member to the community and include:

- Member needs related to housing
- Transportation
- Availability of caregivers
- Other transition needs and supports

The transition plan will also identify any barriers to a safe transition and strategies to overcome those barriers.

The member's care coordinator will also complete a person-centered support plan that includes completing a comprehensive needs assessment, documenting risks and the associated mitigation plan, and making a final determination of cost neutrality. The person-centered support plan will be authorized and initiated prior to the member's transition to the community.

We will not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, we may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, we will seek written review and approval from TennCare prior to denial of any member's request to transition to the community. If TennCare approves the request, we will notify the member in

accordance with TennCare rules and regulations, and the transition assessment protocol; and the member will have the right to appeal the determination.

Wellpoint will approve the transition plan and authorize any covered or cost-effective alternative services included in the plan within 10 business days of completion of the plan. The transition plan will be fully implemented within 90 days from approval of the transition plan, except under extenuating circumstances, which must be documented in writing.

Once completed, Wellpoint will submit to TennCare documentation as specified by TennCare to verify the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member, we'll verify the member has been approved for enrollment in CHOICES Group 2 or 3 (as appropriate) effective as of the planned transition date.

The member's care coordinator will monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.

For members transitioning to a setting other than a community-based residential alternative setting, the care coordinator will upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new person-centered support plan and will take immediate action to resolve any service gaps.

For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first 24 hours, the care coordinator will visit the member in their residence. During the initial 90-day post-transition period, the care coordinator will conduct monthly face-to-face in-home visits to ensure that the:

- Person-centered support plan is being followed.
- Person-centered support plan continues to meet the member's needs.
- Member has successfully transitioned to the community.

For members transitioning to a community-based residential alternative setting or who will be living with a relative or other caregiver, within the first 24 hours, the care coordinator will contact the member and within seven days after the person has transitioned to the community, the care coordinator will visit the member in their new residence. During the initial 90-day post-transition period, the care coordinator will:

- Contact the member by telephone each month to ensure that the person-centered support plan:
  - Is being followed.
  - Continues to meet the member's needs.
- Ensure the member has successfully transitioned to the community.
- Conduct additional face-to-face visits as necessary to address issues and/or concerns.
- Ensure the members' needs are met.

The member's care coordinator will monitor hospitalizations and short-term nursing facility stays for members who transition to identify and address issues that may prevent the member's long-term community placement.

We will:

- Monitor hospitalizations and nursing facility readmission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.
- Coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions.
- Develop and implement any necessary assessment tools, transition plan templates, protocols or training necessary to ensure issues that may hinder a member's successful transition are identified and addressed. Any tool, template or protocol must be prior approved in writing by TennCare.

Nursing Facility Blended Rates

Effective July 1, 2018, there are no longer distinct Level 1 and Level 2 nursing facility rates in the CHOICES program. Under the new reimbursement system, each nursing facility has a blended quality-and acuity-adjusted per diem rate which takes into account the case mix of residents in the facility and the facility's performance in QuILTSS. The new TennCare Rule 1200-13-02 (available at **http://publications.tnsosfiles.com/rules_filings/05-01-18.pdf**) which operationalizes the new reimbursement system became effective on July 30, 2018.

As a reminder, Level 1 bed hold days are no longer covered and should not be billed effective July 1, 2018.

Ongoing Care Coordination

For Individuals Enrolled in CHOICES Group 1

We will provide the following ongoing care coordination to members enrolled in CHOICES Group 1:

- Work with nursing facilities to coordinate the provision of care. A care coordinator assigned to a resident of the nursing facility will participate in quarterly provision of care meetings. At least two of the provision of care meetings per year will be conducted on-site in the facility. The provision of care meetings will identify and address any member who has experienced a potential significant change in needs or circumstances or about whom the nursing facility or Wellpoint has expressed concerns.
- Develop and implement targeted strategies to improve health, functional or quality of life outcomes (for example, strategies related to Condition Care services or pharmacy management or to increase and/or maintain functional abilities), which could include identifying goals for health improvement or community involvement based on the members wishes and desires.

- Coordinate with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic health conditions, including services covered by Wellpoint that are beyond the scope of the nursing facility services benefit.
- Intervene and address issues as they arise regarding payment of patient liability amounts and assist in interventions to address untimely or nonpayment of patient liability in order to avoid the consequences of nonpayment.
- Follow a potential significant change in needs or circumstances for members in CHOICES Group 1 who are residing in a nursing facility and contact the nursing facility to determine if a visit and reassessment is needed:
    - Pattern of recurring falls
    - Incident, injury or complaint
    - Report of abuse or neglect
    - Frequent hospitalizations
    - Prolonged or significant change in health and/or functional status

For Individuals Enrolled in CHOICES Groups 2 and 3

We provide the following ongoing care coordination to members in CHOICES Groups 2 and 3:

- Coordinating regularly scheduled meetings with everyone the member we support considers important to them in order to develop a person-centered support plan and update the plan as needed
- During the development of the member's person-centered support plan and as part of the annual updates, the care coordinator will discuss with the member their interest in consumer direction of HCBS
- During the development of the member's person-centered support plan, the care coordinator will educate the member about their ability to use advance directives and document the member's decision in the member's file
- Ensure the person-centered support plan addresses the member's desired outcomes, needs and preferences
- For members in CHOICES Group 2, each time a member's plan of care is updated to change the level or type of service, document in accordance with TennCare policy that the projected total cost of HCBS, home health care and private duty nursing is less than the member's cost neutrality cap; monitor utilization to identify members who may exceed the cost neutrality cap and to intervene as necessary to maintain the member's community placement; educate members in CHOICES Group 2 about the cost neutrality cap and what will happen if the cap is met.
- For members in CHOICES Group 3, determine whether the cost of HCBS, excluding minor home modifications, will exceed the expenditure cap for CHOICES Group 3. Wellpoint will continuously monitor the member's expenditures and work with the member when they are approaching the limit, including identifying non-LTSS services that will be provided when the limit has been met to prevent/delay the need for institutionalization; each time the person-centered support plan for a member in CHOICES Group 3 is updated, Wellpoint will educate the member about the expenditure cap.

- For new services in an updated person-centered support plan, the care coordinator will provide the member with information about potential providers for each HCBS that will be provided by Wellpoint and assist members with any requests for information that will help the member in choosing a provider and, if applicable, in changing providers, subject to the provider's capacity and willingness to provide service.
- Upon the scheduled initiation of services identified in the person-centered support plan, the member's care coordinator/care coordination team will begin to monitor services to ensure services have been initiated and continue to be provided as authorized; this will include ongoing monitoring via EVV to ensure that services are provided in accordance with the member's person-centered support plan, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; ensure services continue to meet the member's needs.
- Identify and address service gaps, ensure that back-up plans are implemented and effectively working, and evaluate service gaps to determine their cause and to minimize gaps going forward; describe in policies and procedures the process for identifying, responding to and resolving service gaps in a timely manner.
- Identify changes to a member's risk, address those changes and update the person-centered support plan as needed
- Reassess a member's needs and update the member's person-centered support plan in accordance with appropriate requirements and timelines
- Maintain appropriate ongoing communication with community and natural supports to monitor and support their ongoing participation in the member's care
- For services not covered by Wellpoint, coordinate with community organizations that provide services that are important to the health, safety and well-being of members. This may include referrals to other agencies for assistance and assistance as needed with applying for programs, but Wellpoint will not be responsible for the provision or quality of noncovered services provided by other entities.
- Notify TennCare immediately, in the manner specified by TennCare, if Wellpoint determines that the needs of a member in CHOICES Group 2 cannot be met safely in the community and within the member's cost neutrality cap
- Perform additional requirements for consumer direction of HCBS as necessary
- At a minimum, Wellpoint will consider the following a significant change in needs or circumstances for members in CHOICES Groups 2 and 3 residing in the community:
    - Change of residence or primary caregiver or loss of essential social supports
    - Significant change in health and/or functional status
    - Loss of mobility
    - An event that significantly increases the perceived risk to a member
    - Member has been referred to APS because of abuse, neglect or exploitation
- Identify and immediately respond to problems and issues, including circumstances that would impact the member's ability to continue living in the community.

For ALL Individuals Enrolled in CHOICES

Wellpoint will provide for the following ongoing care coordination to all members enrolled in CHOICES:

- Conduct a level of care reassessment at least annually and within five business days of Wellpoint becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility
- If the level of care assessment indicates a change in the level of care or if the assessment was prompted by a request by an enrolled member, a member's representative or caregiver or another entity for a change in level of services, forward the assessment to TennCare for determination
- If the level of care assessment indicates no change in level of care, Wellpoint will document the date the level of care assessment was completed in the member's file; any level of care assessments prompted by a request for a change in level of services will be submitted to TennCare for determination
- Facilitate access to physical and/or behavioral health services as needed, including transportation to services; transportation for HCBS is not included
- Monitor and ensure the provision of covered physical health, behavioral health, and/or LTSS services; and services provided as a cost-effective alternative to other covered services; and ensure that services provided meet the member's needs
- Monitor member's utilization of the emergency department (ED), identify reasons for frequent usage of ED resources and develop strategies to mitigate ongoing utilization of this resource as applicable
- Provide assistance in resolving concerns about service delivery or providers
- Coordinate with a member's PCP, specialists and other providers, such as the member's mental health case manager, to facilitate a comprehensive, holistic, person-centered approach to care
- Contact providers and workers on a periodic basis and coordinate with providers and workers to collaboratively address issues regarding member service delivery and to maximize community placement strategies
- Share relevant information with and among providers and others when information is available, and it is necessary to share for the well-being of the member
- Determine the appropriate course as specified herein upon:
    - Receipt of any contact made by or on behalf of a member, regardless of source, which asserts that the member's needs are not met by currently authorized services
    - The member's hospitalization
    - Other circumstances which warrant review and potential modification of services authorized for the member
- Ensure that all Pre-Admission Screening and Resident Review (PASRR) requirements are met prior to the member's admission to a nursing facility
- Update consent forms as necessary
- Assure that the organization of and documentation included in the member's file meets all applicable Wellpoint standards

We will provide information regarding the role of the care coordinator and will request providers and caregivers to notify a member's care 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. Wellpoint will provide training to key providers and caregivers regarding the value of this communication and remind them that the member identification card indicates if a person is enrolled in CHOICES.

We facilitate timely communication between internal departments and the care coordinator to ensure that each care coordinator receives all relevant information regarding their assigned members (for example, member services, Condition Care services, utilization management and claims processing). The care coordinator will follow up on this information as appropriate (for example, documenting this information in the member's person-centered support plan, monitoring of outcomes, and, as appropriate, conducting a needs reassessment and updating the plan of care).

We will monitor and evaluate a member's emergency department and behavioral health crisis service utilization to determine the reason for these visits. The care coordinator will take appropriate action to facilitate appropriate utilization of these services (for example, communicating with the member's providers, educating the member, conducting a needs reassessment, and/or updating the member's person-centered support plan and to better manage the member's physical health or behavioral health condition(s)).

Care coordinators, or an individual of the care coordination team, are actively involved in discharge planning when a member enrolled in CHOICES is hospitalized. Hospitalized members who are enrolled in CHOICES receive face-to-face visits to complete a needs reassessment and an update to the member's person-centered support plan as needed.

The following observations will be documented at each face-to-face visit:

- Member's physical condition, including observations of the member's skin, weight changes and any visible injuries
- Member's physical environment
- Member's satisfaction with services and care
- Member's upcoming appointments
- Member's mood and emotional well-being
- Member's falls and any resulting injuries
- A statement by the member regarding any concerns or questions
- A statement from the member's representative or caregiver regarding any concerns or questions (when the representative/caregiver is available)

We will identify and immediately respond to problems and issues, including:

- Service gaps.
- Complaints or concerns regarding the quality of care rendered by providers, workers or care coordination staff.

Minimum Care Coordinator Contacts

The care coordinator will conduct all needs assessment and support planning activities and will make all minimum care coordinator contacts as specified below in the member's place of residence except

under extenuating circumstances (such as assessment and support planning conducted during the member's hospitalization or upon the member's request), which will be documented in writing.

While we may grant a member's request to conduct certain care coordination activities outside their place of residence, we are responsible for assessing the member's living environment in order to identify any modifications that may be needed and to identify and address, on an ongoing basis, any issues which may affect the member's health, safety and welfare. Repeated refusal by the member to allow the care coordinator to conduct visits in their home may, subject to review and approval by TennCare, constitute grounds for disenrollment from CHOICES Groups 2 or 3 if we are unable to properly perform monitoring and other contracted functions and to confirm that the member's needs can be safely and effectively met in the home setting.

A member may initiate a request to opt out of some of the minimum face-to-face contacts but only with TennCare review of circumstances and approval. Wellpoint will not encourage a member to request a reduction in face-to-face visits by the care coordinator.

Care coordinators assess each member's need for contact with the care coordinator to meet the person's member need and ensure the member's health and welfare. Members enrolled in CHOICES will be contacted by their care coordinator according to the following time frames:

- Members will receive a face-to-face visit from their care coordinator in their residence within the appropriate time frames.
- Members who are newly admitted to a nursing facility when the admission has not been authorized by Wellpoint will receive a face-to-face visit from their care coordinator within 10 days of notification of admission.
- Members in CHOICES Group 2 who have transitioned from a nursing facility to the community will be contacted per the applicable time frame.
- Within five business days of scheduled initiation of services, the member's care coordinator/care coordination team will contact members in CHOICES Groups 2 and 3 who begin receiving HCBS after the date of enrollment in CHOICES to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).
- Within five business days of scheduled initiation of HCBS in the updated
- person-centered support plan, the member's care coordinator/care coordination team will contact members in CHOICES Groups 2 and 3 to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).
- Members in CHOICES Group 1 (who are residents of a nursing facility) will receive a face-to-face visit from their care coordinator at least twice a year at a reasonable interval.
- Members in CHOICES Group 2 will be contacted by their care coordinator at least monthly either in person or by telephone; these members will be visited in their residence face-to-face by their care coordinator at least quarterly.
- Members in CHOICES Group 3 will be contacted by their care coordinator at least quarterly either in person or by telephone; these members will be visited in their residence face-to-face by their care coordinator a minimum of semi-annually.

Wellpoint ensures member's care coordinator/care coordination team coordinates with Medicare payers, Medicare Advantage plans and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

Wellpoint Responsibilities for Service Coordination

The following table provides a summary of the responsibilities of Wellpoint regarding service coordination for members enrolled in CHOICES.

All Group Individuals and Following All Types of Enrollments					
Setting of Care at Enrollment	**Continuity of Care Coverage**	**Time Frame for Face-to-Face Visits and Needs and Risk Assessment**	**Care Plan Development**	**Service Authorization and Initiation**	**Follow-up Contacts and Assessments**
Applies to all settings.	Wellpoint provides covered LTSS services, including HCBS and nursing facility services, in accordance with previously approved levels, regardless of whether the service is provided by a participating or nonparticipating provider. Wellpoint may not transition a member to another facility (nursing or community-based residential alternative) unless the member or their representative requests/consents to a transfer in writing. If the member resides in a nonparticipating facility at time of enrollment, Wellpoint will: • Provide continuation of those services from that provider for at least 30 calendar days • Authorize continuation of services pending enrollment of the facility as a contract provider or facilitation of the member's transition to a contract facility. • Continue to reimburse services from the noncontract facility.	See specific timelines for face-to-face meetings outlined by setting of care at time of enrollment below. Note: This only applies to enrollment at implementation. If a member is admitted to a nursing facility and the admission was not prior authorized, the care coordinator must conduct a face-to-face visit within 10 business days of notification of admission.	<u>Ongoing Care Coordination</u>: Wellpoint will conduct a level of care reassessment at least annually and within 5 business days of Wellpoint becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. Person-Centered Support Plan: • **Group 1:** Nursing facility develops, and the care coordinator/care coordination team may supplement, as necessary. • **Groups 2 and 3: The** care coordinator develops and must facilitate a support	CHOICES intake for all current members: Wellpoint will authorize and initiate long-term services within 5 business days of notice of the member's enrollment. If Wellpoint is unable to initiate any nursing facility services in accordance with the required time frames below, Wellpoint must issue a written notice to the member documenting the delay, reasons for the delay and the date services will start.	**Group 2 and 3:** If Wellpoint becomes aware of an increase in the member's needs at any time before conducting a comprehensive needs assessment, the member's care coordinator must immediately conduct a comprehensive needs assessment and update the member's person-centered support plan within 10 business days of awareness. If Wellpoint is unable to place a member in a nursing facility requested by the member, the care coordinator must meet with the member and their representative to discuss the reasons why the member cannot be placed with the requested facility and provide alternatives. For members approved for Level II nursing facility services, Wellpoint must monitor the member's continued need for skilled/rehabilitation services and notify TennCare when these services are no longer necessary. Notification must include information needed for TennCare to re-evaluate the level of care. **Group 2 and 3:** Care coordinators/care coordination team must contact a member within 5 business days of scheduled initiation of HCBS services (both at start and when the person-centered support plan is changed) to confirm they are being provided.

			planning team, consisting of the member and the member's care coordinator with the consultation of the member's providers.		

Specific requirements based on group classification and status at/type of enrollment.

	Setting of Care at Enrollment	Continuity of Care Coverage	Time Frame for Face-to-Face Visits and Needs and Risk Assessment	Follow-up Contacts and Assessments
Group 1				
Group 1	**Ongoing**			
	Short-term care facility	See all groups above. Additionally, Wellpoint may not transition a member to HCBS unless they choose to receive HCBS as an alternative to nursing facility care and is enrolled into Group 2.	Conduct face-to-face visit and any necessary needs assessment within 30 calendar days of enrollment.	Care coordinators must participate in Grand Rounds quarterly and conduct a face-to-face visit with a member at least twice a year or more frequently as necessary.
	Nursing facility	See all groups above. Additionally, Wellpoint may not transition a member to HCBS unless they chooses to receive HCBS as an alternative to nursing facility care and is enrolled into Group 2.	Conduct face-to-face visit and any necessary needs assessment within 60 calendar days of enrollment.	Care coordinators must participate in Grand Rounds quarterly and conduct a face-to-face visit with a member at least twice a year or more frequently as necessary.
	Waiting for nursing facility placement	See all groups above.	Conduct face-to-face visit, perform needs assessment and authorize/initiate nursing facility services within 10 calendar days of notice of the member's enrollment.	See all groups above.
Group 1	**New to CHOICES**			
	Short-term care facility	See all groups above. Additionally, Wellpoint may not transition a member to HCBS unless they chooses to receive HCBS as an alternative to nursing facility care and is enrolled into Group 2.	Conduct face-to-face visit and any necessary needs assessment within 30 calendar days from notice of enrollment.	Care coordinators must participate in Grand Rounds quarterly and conduct a face-to-face visit with a member at least twice a year or more frequently as necessary.

	Setting of Care at Enrollment	Continuity of Care Coverage	Time Frame for Face-to-Face Visits and Needs and Risk Assessment	Follow-up Contacts and Assessments
	Nursing facility days	See all groups above. Additionally, Wellpoint may not transition a member to HCBS unless they choose to receive HCBS as an alternative to nursing facility care and is enrolled into Group 2.	Conduct face-to-face visit and any necessary needs assessment within 30 calendar days from notice of enrollment.	Care coordinators must participate in Grand Rounds quarterly and conduct a face-to-face visit with a member at least twice a year or more frequently as necessary.
GROUP 2				
	Ongoing			
Group 2	All members	See all groups above. Wellpoint must continue authorized LTSS services (except case management) for a minimum of 30 calendar days. Wellpoint cannot reduce services until their new care coordinator has conducted a comprehensive needs assessment, developed a person-centered support plan and authorized/initiated HCBS in accordance with this plan. Wellpoint may not transfer a member into a nursing facility unless they require a short-term stay or chooses to transition to a nursing facility and/or we determine we cannot meet the needs of the member within the cost neutrality cap, and the member agrees to enroll in Group 1.	Conduct face-to-face visit, perform comprehensive needs assessment including risk assessment and agreement, develop a person-centered support plan and authorize/initiate HCBS within 10 business days of notice of enrollment or prior to the expiration date of the approved level of nursing services, whichever is soonest. If the expiration date for the level of nursing facility services approved by TennCare occurs prior to 30 calendar days after enrollment and Wellpoint is unable to conduct the visit prior to the expiration date, Wellpoint must be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate.	Members must be contacted by their care coordinator at least monthly either in person or by telephone. These members must be visited in their residence face to face by their care coordinator at least quarterly.
	New to CHOICES			
Group 2	Receiving Community-Based Residential Alternative (CBRA) services	See all groups above. Wellpoint must continue authorized LTSS services (except case management) for a minimum of 30 calendar days. Wellpoint cannot reduce services until their new care coordinator conducts a comprehensive needs assessment, develops a person-centered support plan and authorizes/initiates HCBS in accordance with this plan.	Conduct face-to-face visit, perform comprehensive needs assessment, develop a person-centered support plan and authorize/initiate HCBS within 10 business days of notice of enrollment.	Members must be contacted by their care coordinator at least monthly either in person or by telephone. These members must be visited in their residence face to face by their care coordinator at least quarterly.

	Setting of Care at Enrollment	Continuity of Care Coverage	Time Frame for Face-to-Face Visits and Needs and Risk Assessment	Follow-up Contacts and Assessments
		Wellpoint may not transfer a member into a nursing facility unless they require a short term- stay or chooses to transition to a nursing facility and/or we determine we cannot meet the needs of the member within the cost neutrality cap, and the member agrees to enroll in Group 1.		
	Not currently receiving CBRA	See all groups above. Wellpoint must continue authorized LTSS services (except case management) for a minimum of 30 calendar days. Wellpoint cannot reduce services until their new care coordinator has conducted a comprehensive needs assessment, developed a person-centered support plan and authorized/initiated HCBS in accordance with this plan. Wellpoint may not transfer a member into a nursing facility unless they require a short-term stay or chooses to transition to a nursing facility and/or we determine we cannot meet the needs of the member within cost neutrality cap, and the member agrees to enroll in Group 1.	Conduct face-to-face visit, perform comprehensive needs assessment, develop a person-centered support plan and authorize/initiate HCBS within 10 business days of notice of enrollment.	Members must be contacted by their care coordinator at least monthly either in person or by telephone. These members must be visited in their residence face to face by their care coordinator at least quarterly.
GROUP 3				
Group 3	**Ongoing**			
	All members	See all groups above. Wellpoint must continue authorized LTSS services (except case management) for a minimum of 30 calendar days. Wellpoint cannot reduce services until the new care coordinator has conducted a comprehensive needs assessment, developed a person-centered support plan and authorized/initiated HCBS in accordance with this plan. Wellpoint may not transfer a member into a nursing facility unless they require a short-term stay or chooses to transition to a nursing facility and/or we	Conduct face-to-face visit, perform comprehensive needs assessment including risk assessment, develop a person-centered support plan and authorize/initiate HCBS within 10 business days of notice of enrollment or prior to the expiration date of the approved level of nursing services, whichever is soonest. If the expiration date for the level of nursing facility services approved by TennCare occurs prior to 30 calendar days after enrollment and	Members must be contacted by their care coordinator at least quarterly either in person or by telephone. These members must be visited in their residence face to face by their care coordinator semiannually at a minimum.

	Setting of Care at Enrollment	Continuity of Care Coverage	Time Frame for Face-to-Face Visits and Needs and Risk Assessment	Follow-up Contacts and Assessments
		determine we cannot meet the needs of the member within the cost neutrality cap, and the member agrees to enroll in Group 1.	Wellpoint is unable to conduct the visit prior to the expiration date, Wellpoint must be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate.	
Group 3	**New to CHOICES**			
	All members	See all groups above. Wellpoint must not admit a member to a nursing facility unless the member meets facility level of care, is expected to require it for more than 90 calendar-days and agrees to transition and enroll in Group 1.	Conduct face-to-face visit, perform comprehensive needs assessment, develop a person-centered support plan and authorize/initiate HCBS within 10 business days of notice of enrollment.	Members must be contacted by their care coordinator at least quarterly either in person or by telephone. These members must be visited in their residence face to face by their care coordinator a minimum of semiannually

Mandatory Child Abuse Reporting

Any person who has knowledge of or is called upon to render aid to any child who is suffering from or has sustained any wound, injury, disability, or physical or mental condition will report such harm immediately if the harm is of such a nature as to reasonably indicate that it has been caused by brutality, abuse or neglect or that, on the basis of available information, reasonably appears to have been caused by brutality, abuse or neglect.

Any such person with knowledge of the type of harm described in this section will report it by telephone or otherwise to the:

- Judge having juvenile jurisdiction over the child
- Department, in a manner specified by the department, either by contacting a local representative of the department or by utilizing the department's centralized intake procedure, where applicable
- Sheriff of the county where the child resides
- Chief law enforcement official of the municipality where the child resides; if any such person knows or has reasonable cause to suspect that a child has been sexually abused, relative to the sexual abuse of children, regardless of whether such person knows or believes that the child has sustained any apparent injury as a result of such abuse

The report will include, to the extent known by the reporter, the name, address and age of the child; the name and address of the person responsible for the care of the child; and the facts requiring the report. The report may include any other pertinent information.

Reports involving known or suspected institutional child sexual abuse will be made and received in the same manner as all other reports made pursuant to applicable federal and state laws including Tenn. Code Ann. § 37-1-605 and § 37-1-401-414, relative to the sexual abuse of children.

Every physician or other person who makes a diagnosis of, treats or prescribes for any sexually transmitted disease or venereal herpes and Chlamydia in children 13 years of age or younger; and every superintendent or manager of a clinic, dispensary, charitable or penal institution in which there is a case of any of the diseases, in children 13 years of age or younger, will report the case immediately in writing on a form supplied by the Department of Health. If the reported cases are confirmed and if sexual abuse is suspected, the Department of Health will report the case to the Department of Children's Services. The Department of Children's Services will be responsible for any necessary follow-up.

Every physician or other person who makes an initial diagnosis of pregnancy to an unemancipated minor; and every superintendent or manager of a clinic, dispensary or charitable or penal institution in which there is a case of an unemancipated minor who is determined to be pregnant will provide to the minor's parent, if the parent is present and the minor consents, any readily available written information on how to report to the department of children's services an occurrence of sex abuse that may have resulted in the minor's pregnancy unless disclosure to the parent would violate the federal

Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. section 1320d et seq., or the regulations promulgated pursuant to the act.
The Department of Children's Services will provide the Department of Health the relevant written information. The Department of Health will distribute copies of the written information to all licensees of the appropriate health-related boards through the boards' routinely issued newsletters. At the time of initial licensure, these boards will also provide new licensees a copy of the relevant written information for distribution.

Nothing in this section will be construed to prohibit any hospital, clinic, school or other organization responsible for the care of children from developing a specific procedure for internally tracking, reporting or otherwise monitoring a report made by a member of the organization's staff pursuant to this section, including requiring a member of the organization's staff who makes a report to provide a copy of or notice concerning the report to the organization as long as the procedure does not inhibit, interfere with or otherwise affect the duty of a person to make a report. Nothing in this section will prevent staff of a hospital or clinic from gathering sufficient information, as determined by the hospital or clinic, in order to make an appropriate medical diagnosis or to provide and document care that is medically indicated and needed to determine whether to report an incident as defined in this part. Those activities will not interfere with nor serve as a substitute for any investigation by law enforcement officials or the department.

Elder Abuse

(Excerpt from Tennessee Department of Human Services)

Older adults and those adults with disabilities want to live independently. They need to be safe and as independent as possible. Many cannot depend upon or trust those nearest to them. Those they love the most may abuse them.

Only 1 in 23 cases are reported. It is not only your moral and ethical obligation to report elder abuse but also your legal obligation.

The types of adult abuse include:

- **Neglect** occurs when the basic needs of a dependent adult are not met by a caregiver. Neglect may be unintentional, resulting from the caregiver's lack of ability to provide or arrange for the care or services the adult requires. Neglect also may be due to the intentional failure of the caregiver to meet the adult's needs.
- **Self-neglect** occurs when a dependent adult is unable to care for them or to obtain needed care. The impairments result in significant danger to the adult, and in some situations, deterioration can occur to the point that the adult's life may be at risk.
- **Abuse (physical, sexual and emotional)** generally involves more extreme forms of harm to the adult, including the infliction of pain, injury, mental anguish, unreasonable confinement or other cruel treatment.
- **Financial exploitation** occurs when a caregiver improperly uses funds intended for the care or use of the adult. These are funds paid to the adult or to the caregiver by a governmental agency.

To report abuse, please contact the Department of Human Services, Adult Protective Services Division Abuse Hotline, which serves adults age 18 or older who are abused, neglected or financially exploited and unable to protect themselves due to mental or physical disabilities or advanced age.

Please call: **888-APS-TENN** (**888-277-8366**) or local offices at:

- Davidson County: **615-532-3492**
- Hamilton County: **423-634-6624**
- Knox County: **865-594-5685**
- Shelby County: **901-543-7800**

If the victim of abuse resides in a residential home for the aged, an assisted living, or a nursing home, reports may be made to:

- Adult Protective Services: **888-277-8366**
- Department of Health: **877-287-0010**
- Long Term Care Ombudsman Program: **877-236-0013**

If the victim resides in a mental health group home, reports may be made to:

- East Tennessee, Cynthia Headrick at **865-594-6551**, or via email at cynthia.headrick@state.tn.us
- Middle Tennessee, Ann Turner-Brooks at **615-532-6594**, or via email at ann.t.brooks@state.tn.us
- West Tennessee, Phil Brown at **901-543-7442**, or via email at phil.brown@state.tn.us

Reportable Event Management and Quality Monitoring

Applicable CHOICES Groups 2 and 3 only.

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

Providers and individual staff persons who provide HCBS and/or ICF/IID services are accountable for ensuring the supports are provided in accordance with each individual's PCSP, including implementation of strategies identified to help mitigate risk, but should not be held responsible if, despite appropriate supports and implementation of appropriate and reasonable risk mitigation strategies, an untoward event occurs. The CHOICES, ECF CHOICES, Katie Beckett, 1915(c) waiver, and ICF/IID programs acknowledge and value dignity of choice and recognize that the normal taking of risks in life is essential for personal growth and development and maximizing quality of life.

There are three (3) categories of Reportable Events: Tier 1, Tier 2, and Additional Reportable Events and Interventions. The One Reportable Event Management System Definitions Document defines each

category and lists the event per category. The type of Reportable Event dictates the reporting requirements and process that must be followed by the provider, MCO, FEA, and DIDD, as applicable. DIDD shall triage all allegations reported via the Abuse Hotline and/or via Reportable Event Form within two business days (unless pending results of medical assessment, laboratory test, or expert opinion) to determine the need for an investigation. The Event Management Coordinator (EMC) or designee shall provide all requested documentation and information as soon as possible to ensure the disposition is reached within the required two (2) business days. Once a disposition is reached by DIDD, the responsible provider is notified of the outcome via email by the On-Call Investigator.

The REM system is designed to:

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

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

Reportable Event Data Review, Collection, & Analysis

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

Each contracted provider is responsible for the designation of an Event Management Coordinator (EMC). ECF CHOICES, CHOICES, Katie Beckett, 1915(c), and ICF/IID provider agencies that provide day, residential and personal assistance services will develop a Provider Reportable Event Review Team (PRERT). The purpose of the PRERT is to review and evaluate the provider's reportable events, investigations, and trends to inform internal prevention strategies. The PRERT shall meet regularly, but

no less than monthly, and individual and representation is specific to each provider's Event Management policy. PRERT meetings will be documented and will reflect discussion and follow up actions concerning reported events and investigations, their causes, actions taken, and recommendations made by the review team.

DIDD's Abuse Hotline (888-633-1313)

Quality Monitoring

Wellpoint is responsible for ensuring that each Community Living Supports (CLS) provider within the CHOICES network maintains compliance related to quality of care and service provision. This is accomplished through oversight and monitoring by the Wellpoint Provider Relations and quality teams.

Quality monitoring focuses on the quality of services that go above and beyond the minimum of quality standards. Wellpoint collaborates with DIDD and TennCare for certain CHOICES services, as outlined in the contractor risk agreement and TennCare protocol.

Wellpoint will utilize the information obtained through DIDD Quality Monitoring surveys in determining the appropriate course of action to support and/or counsel each provider in the CHOICES network, but Wellpoint maintains sole responsibility for the quality of providers in the CHOICES network. Quality monitoring of CHOICES services shall include only CLS and CLS-FM. Upon the first initiation of services by a CHOICES CLS or CLS-FM provider to one or more CHOICES members (that is, the first time the provider begins delivering services in the program), Wellpoint shall notify DIDD of service initiation within ten (10) business days of the initiation of services for purposes of scheduling consultative quality monitoring surveys, as applicable, with DIDD.

The following list outlines all services for quality monitoring:

Day

- Community Integration Support Services
- Day Services
- Community Participation
- Personal Assistance
- Independent Living Skills Training

Independent Support Coordination (ISC agencies)

Support

- Community Integration Support Services
- Independent Living Skills Training
- Personal Assistance
- Respite (in conjunction with Personal Assistance and Supportive Home Care, not as a separate service)

- Supportive Home Care
- Enabling Technology Services

Residential

- ECF Choices Community Living Supports (CLS)
- ECF Choices CLS Family Model (FM)
- 1915c Residential services (Semi Independent Living, Supported Living, Residential Habilitation, Family Model, Medical Residential)
- Choices CLS
- Choices CLS FM

Clinical

- Behavior Services
- Therapy Services (Occupational, Physical & Speech, Language and Hearing)
- Nursing Services
- Nutrition Services
- Orientation & Mobility Services

Employment Services

- Exploration
- Discovery
- Situational Observation and Assessment
- Job Development Plan or Self Employment Plan
- Job Development or Self Employment Start Up
- Job Coaching, Integrated, Competitive Employment
- Job Coaching, Self-Employment
- Coworker Supports
- Career Advancement
- Supported Employment – Small Group Supports
- Integrated Employment Path Services
- Career Advancement
- Day and Employment Services

Quality Monitoring Consultative and Annual Survey Process

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

On completion of the Consultative Survey, providers will be placed on the annual quality monitoring survey schedule. Following the completion of the annual survey, each provider will receive a Quality Monitoring Survey Report with narrative feedback, and a performance level rating and preferred

provider status. Additional information regarding the Quality Assurance and Monitoring survey process is on the DIDD website at **https://www.tn.gov/didd/divisions/quality-management/quality-assurance.html**.

Fraud, Waste, and Abuse

Pursuant to the *TennCare CRA*, during both credentialing and recredentialing site visits, MCOs are required to verify that CHOICES providers have policies and processes concerning Fraud, Waste and Abuse training for employees, that providers have policies and processes concerning training on Fraud, Waste and Abuse including the False Claims Act, and Whistleblowers Protection, how to report FWA and information on medical records standards including cloning medical notes and possible consequences. This information is included within the review of the Succession Planning.

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. This includes any act that constitutes fraud under applicable Federal or State law.
- **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**: behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.

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

Presentation of a member identification card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website and telephonic verification may be obtained through the automated Provider Inquiry Line at **833-731-2154** .

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

Reporting Fraud, Waste and Abuse

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

You can report your concerns by:

- Visiting our education site **www.fighthealthcarefraud.com**, clicking click **Report it** and completing the ***Report Waste, Fraud and Abuse*** form
- Calling Provider Services if you are a contracted provider.
- Calling our Special Investigations Unit fraud hotline at **866-847-8247**.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud but be advised that we do not routinely update 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 – for example, cloning Medical Records/Notes and Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, member information. All documentation in the medical record must be specific to the patient and their situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization

- Soliciting, offering or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was performed

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

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

Examples of Member Fraud, Waste and Abuse:

- Forging, altering or selling prescriptions
- Letting someone else use the member's identification card
- Relocating to out-of-service plan area and not letting us know
- Using someone else's identification card

When reporting concerns involving a member include:

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

Investigation Process

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 review:** We review medical records in context to previously submitted claims and/or to substantiate allegations.
- **Prepayment Review**: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.

- **Recoveries:** We recover overpayments directly from the Provider. Failure of the Provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

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

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

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

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

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

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

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate

activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

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

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including Provider termination
- Will be referred to other authorities as applicable and/or designated by the State

The SIU will refer all suspected criminal activity committed by a Member or Provider to the appropriate regulatory and law enforcement agencies

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

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

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

HIPAA

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

- Our company recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose;

conversely, network providers should only request the minimum necessary 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 an 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 members who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.
- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (for example, Excel spreadsheets with claim information; such information should be mailed or faxed.)
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific member, 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 member information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the provider's name, address and TIN or member's provider number.

Employee Education about the False Claims Act

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

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

CHOICES Provider Background Check Requirements

Pursuant to the *TennCare CRA*, during both credentialing and recredentialing site visits, MCOs are required to verify that CHOICES providers have policies and processes concerning criminal background checks including registry checks for employees and volunteers, that these providers have conducted all required criminal background checks including registry checks, and that providers have policies and

processes concerning individualized assessments for applicants for employment who have criminal backgrounds.

- Providers are required to maintain a criminal background check roster that contains evidence and details of background checks of employees that support CHOICES members. This roster will be used and shared with each MCO.
- Tracking of employees for this process must begin using the *Provider Criminal Background Check Roster* as of July 1, 2017.
- Employees will be categorized as having direct contact and/or incidental contact with a member.
- Providers will be required to sign attestation forms during initial and/or recredentialing visits conducted by the MCOs. Attestations will be provided to TennCare to validate that applicable background checks are conducted.
- Providers must make organizational payroll documentation from the previous month for employees that support CHOICES members available to the MCO during the site visit.
- Organizational payroll documentation will be used by the MCO to audit and validate employees that are compensated to support CHOICES members against the *Provider Criminal Background Check Roster*.
- Volunteers who support CHOICES members will be validated using the attestation form.
- Employees that support CHOICES members must have background checks completed and vetted prior to having direct contact with members as opposed to before being hired.
- MCOs will audit a sample of employee files and background checks (as opposed to 100 percent of employee files) that support CHOICES members.

Effective July 1, 2017, all contracted CHOICES providers will begin tracking the following information utilizing the *Provider Criminal Background Check Roster* for employees and volunteers:

- Employee or volunteer name
- Employee or volunteer Social Security number
- Title
- Hire date (or start date if a volunteer)
- First date providing services to members
- Criminal background check date (for employees and volunteers with direct contact only)
- Tennessee Abuse Registry check date
- National Sex Offender Registry check date
- Tennessee Sex Offender Registry check date
- List of Excluded Individuals/Entities (LEIE) check date
- Whether the employee or volunteer's record was audited, if applicable, by one of the MCOs during their credentialing visit, and if so, the date of the audit and the name of the MCO that completed the audit

Employees and volunteers who will have direct contact with members must have a criminal background check including registry checks that include verification that the employee or volunteer's name does not appear on the Tennessee Abuse Registry, the National Sex Offender Registry, the Tennessee Sex Offender Registry or the LEIE. For all volunteers and employees who qualify to provide

services constituting only incidental contact with members, the provider shall maintain proof that requisite registry checks were completed.

- If a potential employee or volunteer's name appears on any of the preceding registries, that member is disqualified from providing services to a CHOICES member.
- If a potential employee or volunteer's criminal background check returns results, the
- provider must use their discretion as to whether that member is appropriate to have direct contact with members and must provide the potential employee with a member an individualized assessment taking into account the following three factors:
    - 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 receiving services at risk
    - The nature and gravity of the offense or conduct such as whether the offense is related to physical, sexual or emotional abuse of another person; whether the offense involves violence against another person; or whether the offense involves the manufacture, sale or distribution of drugs
    - 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 members 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 a member from having incidental contact with a member. Such registry checks must be performed prior to any employee or volunteer having any incidental contact with the member.

For all volunteers and employees who qualify to provide services constituting only incidental contact with persons, the CHOICES provider shall maintain proof that requisite registry checks were completed and will be subject to MCO review during credentialing and recredentialing visits as requested.

Note: The effective date of the new background check process is July 1, 2017. However, all employees hired on or after January 1, 2017, must be recorded on the Provider Criminal Background Check Roster.

A copy of the *Provider Criminal Background Check Roster* and the *Provider Criminal Background Check Attestation* must be maintained at your office for MCOs to utilize during onsite reviews.

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

Home and Community-Based Services Settings Rule Compliance

HCBS:

- Is integrated in and supports access to the greater community.

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

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

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

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

The Wellpoint Settings Compliance Committee for CHOICES will review referrals provided from the care coordinator leadership and, as part of their review, they will complete the following:

- Reviewing any proposed or emergency right restrictions and restraints included and not included in a Behavioral Support Plan (BSP), PCSP or POC for potential human rights violations and ensuring informed consent of any restriction.
- Provide input for any modifications to member's rights when the member resides in a provider owned or controlled residential setting prior to modification being included in member's person-centered support plan.
- Review potential violations to HCBS Settings Rules in instances in which a member is living in an unlicensed setting or licensed setting other than those covered in benefits for CHOICES members

that may be in violation of HCBS Settings Rules and make recommendations for coming into compliance with HCBS Settings rules.
- Review of the number of psychotropic medications being prescribed including use of PRN psychotropic medication.
- Reviewing and make recommendations regarding complaints received pertaining to potential human rights violations.
- Ensuring that proposed restriction is the least restrictive viable alternative and is not excessive.
- Ensuring that proposed restriction is not for staff convenience.

Claims Submission

Electronic Submission
Wellpoint encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 120 days from the date of service for inpatient services or from the date of service for outpatient services except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Wellpoint receives notification from TennCare of the member's eligibility/enrollment.

Availity is our designated 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 **availity.com** and select **REGISTER**. If you have any questions or concerns, please contact Availity at **800-AVAILITY (800-282-4548).**

Availity Payer ID: 26375
Phone: **800-282-4548**

Providers have the option of submitting claims electronically through EDI. The advantages of electronic claims submission are as follows:
- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims

The EDI claim submission guide includes additional information related to the EDI claim process.

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

It is 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 **833-731-2154** .

Electronic Visit Verification System
Select HCBS providers must submit claims through the Electronic Visit Verification system (see previous EVV Section).

Paper Claims Submission
Providers also have the option of submitting paper claims. All claims should be submitted on original Red claim forms (not black and white or photocopied forms) laser printed or typed (not handwritten) in a large, dark font. The time frames for submitting a corrected claim via UB-04 CMS-1450 or CMS-1500 (08-05) must be within 120 days from the date of discharge for inpatient services or from the date of service for outpatient services except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Wellpoint receives notification from TennCare of the member's eligibility/enrollment.

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

- Patient's ID number
- Patient's name
- Patient's date of birth
- Patient's account number
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- Procedures, services or supplies rendered CPT-4 codes/HCPCS codes/DRGs with appropriate modifiers if necessary
- National Drug Codes (NDC)
- Present On Admission (POA) indicators
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- NPI of billing and rendering provider when applicable
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification

- Name of referring physician
- NPI of referring physician when applicable
- Any other state required data

Paper claims must be submitted within 120 days of the date of service except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Wellpoint receives notification from TennCare of the member's eligibility/enrollment. Paper claims must be submitted to the following address:

Wellpoint Tennessee, Inc. – TN Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Website Submission
Participating providers have the option to utilize the claim submission utilities available on the Wellpoint provider website. Providers will have the ability to enter claims on a preformatted CMS-1500 and/or UB-04 claim template. Provider offices and facilities that are able to create HIPAA compliant ANSI 837 4010A1 claim transactions will have the ability to upload the claims on the provider website. In order to take advantage of the direct submission of ANSI 837 claim files, please contact our EDI Hotline at **800-590-5745.**

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

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

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

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

Claims Adjudication
Wellpoint is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims that are submitted for adjudication are

processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Hospital facility claims should be submitted using the *CMS-1450 (UB-04)* and provider services using the *CMS-1500*.

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

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

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

- Submit claims within 120 days from the date the service is rendered or for inpatient claims filed by a hospital, within 120 days from the date of discharge.
- In the case of other insurance, submit the claim within 120 days of receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 120 days from the date the eligibility is added, and Wellpoint is notified of the eligibility/enrollment.
- Claims submitted after the 120-day filing deadline will be denied.
- Corrected claims must be submitted within 120 days from the date of services or within 60 days from the date of the Explanation of Payment (EOP), whichever is later.

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

Clean Claims Adjudication

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

- Is submitted by a provider in a timely manner.
- Is accurate.
- Is submitted on a HIPAA compliant standard claim form, including a CMS-1500 (08-05) or *CMS-1450 (UB-04)*, or successor forms thereto or the electronic equivalent of such claim form.
- Is a complete claims submission following any and all HIPAA compliance standards (Levels 1-7).
- Includes a National Provider Identifier and taxonomy information for rendering, attending and billing providers.
- Includes, for all J-codes billed, required NDC code and drug pricing information (NDC quantity, unit price and unit of measurement); exceptions are:
    - Vaccines for children, which are paid as an administrative fee.
    - Inpatient-administered drugs.

    - Radiopharmaceuticals unless the drug is billed separately from the procedure.
- Requires no further information, adjustment or alteration by a provider in order to be processed and paid by Wellpoint.

Wellpoint is required, per the *TennCare CRA,* to adjudicate 90% of clean claims for nursing facility services and CHOICES HCBS and ECF CHOICES HCBS within 14 calendar days and 99.5 percent within 21 calendar days of receipt of a clean claim.

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

Claims Related to Change of Ownership
In the event a provider's contract is terminated because of a change of ownership, Wellpoint 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.

Claims Status
Providers should use our website (**provider.wellpoint.com/tn/**) or call the automated Provider Inquiry Line (**866-840-4991**) to check claims status. Providers should also use the claims status information available for claims that were electronically submitted through a clearinghouse for information on accepted and rejected claims.

Electronic Data Interchange (EDI)
Wellpoint uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient and cost-effective way for providers and employers to do business.

Advantages of Electronic Data Interchange (EDI)
- Process claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction
- Reduce overhead and administrative costs by eliminating paper claim submissions

Use Availity for the following EDI transactions:
- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Ways you can use the Availity EDI Gateway
Availity's EDI submission options:
EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

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

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

Payer ID
Claim Payer ID: 26375

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

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

Use Availity to register and manage ERA account changes with these three easy steps:
1. Log in to Availity **https://apps.availity.com/availity/web/public.elegant.login**
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**

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

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

Effective November 1, 2021, EnrollSafe is the only option for providers to enroll or make changes for EFT payment.

Visit **provider.wellpoint.com/tn/claims/electronic-data-interchange** for EFT registration instructions.

Contact Availity
Please contact Availity Client Services with any questions at **800-Availity (282-4548**).

Provider Payment Disputes and Independent Review

Providers can submit claim payment reconsiderations verbally, in writing, or electronically. Providers have the ability to submit claim reconsideration requests through Availity with more robust functionality. For providers, this means an enhanced experience when:

- Filing a claim payment reconsideration.
- Sending supporting documentation.
- Checking the status of your claim payment reconsideration.
- Viewing your claim payment reconsideration history.

Availity functionality includes:

- Acknowledgement of submission at the time of submission.
- Email notification when a reconsideration has been finalized by
- A worklist of open submissions to check a reconsideration status.

With the new electronic functionality, when a claim payment reconsideration is submitted through Availity, we will investigate the request and communicate an outcome through Availity. Once an outcome has been determined, the Availity user who submitted the claims payment reconsideration will receive an email notification informing them that the reconsideration review has been completed. If you are not satisfied with the reconsideration outcome, continue to follow the existing process to file an appeal, as outlined in your provider manual.

CHOICES/Money Follows the Person Materials and Logos

Providers are prohibited from altering in any manner official CHOICES brochures or other CHOICES or unless Wellpoint has submitted a request to do so to TennCare and obtained prior written approval from TennCare.

Providers are prohibited from reproducing for their own use the CHOICES unless Wellpoint has submitted a request to do so to TennCare and obtained prior written approval from TennCare.

Individual Care

Wellpoint requires its HCBS providers to have a policy requiring personal care service providers to visually confirm a member’s presence upon arriving to a member’s home to deliver services.

provider.wellpoint.com/tn

Medicaid services provided by Wellpoint Tennessee, Inc. We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call **833-731-2154**. Information about the civil rights laws can be found at **tn.gov/tenncare/members-applicants/civil-rights-compliance.html**.