# Medicaid Managed Care Contract Matrix: Tennessee

| Programmatic Element | Standards | Source |
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| **Program Name** | Employment and Community First (ECF) CHOICES - A managed long-term services and supports program that offers home and community-based services (HCBS) to eligible individuals with intellectual and developmental disabilities enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option. | |
| **Date of Transition** | July 1, 2016 | |
| **Total Enrollment** | 2,586 (as of December 2018) | TennCare Section 1115 Quarterly Report (For the period January - March 2018) |
| **Enrollment Type** | Voluntary | |
| **Plans Operating in the State** | Amerigroup, BlueCare, UnitedHealthcare | TennCare ECF CHOICES webpage |
| **Authority for Managed Care** | 1115 | TennCare 1115 Waiver |
| **Eligibility** | ECF CHOICES is a program for individuals with ID and DD who are newly enrolling into the HCBS program, including those not eligible for a 1915 (c) waiver or on a waiver waiting list. Following implementation nearly all new enrollees for HCBS services were directed to ECF CHOICES.[1] ECF CHOICES members have to receive LTSS in each month to remain eligible (with certain exceptions).<br><br>ECF CHOICES HCBS are provided to individuals who fall within the following eligibility groups[2] as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility: | Definitions<br>2.6.1.6.11<br>2.9.6.2.3.1<br>2.9.6.3.3<br>2.9.6.3.4 |

[1] Individuals receiving ICF/IDD services or enrolled in one of Tennessee's three 1915 (c) waivers for individuals with ID (individuals with DD only are not eligible for Tennessee's waiver programs) have been enrolled in managed care since 1994. They receive all of their covered physical and behavioral health services through managed are, but their LTSS is delivered via the fee-for service Medicaid program. The ICF/IDD services and existing 1915 (c) waivers continue to operate.

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| | • Essential Family Supports (Group 4)—Children and adults with I/DD living at home with family who meet the nursing facility level of care (NF LOC) and need and are receiving HCBS as an alternative to nursing facility care, or who, in the absence of HCBS, are "at risk" of nursing facility placement.[3]<br>• Essential Supports for Employment and Independent Living (Group 5)—Adults age 21 and older, unless otherwise specified by TennCare, with I/DD who do not meet nursing facility level of care, but who, in the absence of HCBS are "at risk" of nursing facility placement.[4] An eligible adult age 21 and older who meets NF LOC may enroll in ECF CHOICES Group 5, so long as the person's needs can be safely and appropriately met in the community and at a cost that does not exceed the expenditure cap, including individuals with I/DD who have an aging caregiver. On a case-by-case basis, TennCare may grant an exception to permit adults ages 18 to 20 with I/DD not living at home with family, including young adults with I/DD transitioning out of state custody, to enroll in Group 5, if they meet eligibility criteria.<br>• Comprehensive Supports for Employment and Community Living (Group 6)—Adults age 21 and older, unless otherwise specified by TennCare, with I/DD who meet NF LOC and need and are receiving specialized services for I/DD. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TennCare may grant an exception to permit adults ages 18 to 20 with I/DD not living at home with family, including young adults with I/DD transitioning out of state custody, to enroll in Group 6, if they meet eligibility criteria.<br>• Intensive Behavioral Family Supports (Group 7)—Children under age 21 who live at home with family caregivers and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm, threaten the sustainability of the family living arrangement, and place the child at significant risk of placement outside the home (e.g., state custody, hospitalization, residential treatment, incarceration). The child must meet the NF LOC and need and receive HCBS as an alternative to nursing facility care. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. This group must be implemented by MCO based on TennCare's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements. | 2.9.6.3.14<br>Amendment 27: Employment and Community First CHOICE TennCare II Demonstration |

[2] Eligibility for ECF CHOICES is determined by TennCare. TennCare assesses whether the potential applicant appears to meet categorical and financial eligibility criteria and the potential applicant appears to meet level of care eligibility for enrollment in ECF CHOICES. MCOs are required to educate members that may be eligible for or are referred for ECF CHOICES and assist members in taking the necessary steps to obtain the TennCare assessment. MCOs must document that they attempted to contact the member to provide information on the screening process at least three times over a period of no less than three days. MCOs must also assist members in obtaining required documentation to confirm eligibility for categories.

[3] To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

[4] To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

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| | • Comprehensive Behavioral Supports for Employment and Community Living (Group 8)—Adults age 21 and older, unless otherwise specified by TennCare, with I/DD and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment, meet NF LOC, and need and are receiving specialized services for I/DD. A person must be in one of the following target groups: 1) adults with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the individual due to the severity and frequency of behaviors; 2) emerging young adults (age 18-21) with I/DD and severe psychiatric or behavioral symptoms aging out of the foster care system; and 3) adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term institutional placement (including residential psychiatric treatment facility). To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TennCare may grant an exception to permit adults ages 18 to 20 with I/DD not living at home with family, including young adults with I/DD transitioning out of state custody, to enroll in Group 8, if they meet eligibility criteria.<br><br>MCOs may request disenrollment from ECF CHOICES and managed care if the plan:<br><br>• Cannot safely and effectively meet the member's needs at a cost that is less than the member' expenditure cap when the member is unable or unwilling to transition to a different ECF CHOICES Group in which the member's needs could be safely and effectively met within the expenditure cap that would be applied in that Group<br>• A member in any ECF CHOICES Group who repeatedly refuses to allow a support coordinator entrance into his/her place of residence<br>• A member in any ECF CHOICES Group who refuses to receive critical HCBS as identified through a comprehensive assessment and documented in the member's PCSP<br>• A member in any ECF CHOICES Group who refuses to pay his or her patient liability and for whom the plan is either: 1) in the case of persons receiving community-based residential alternatives (CBRA) services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the MCO is unwilling to continue to serve the member, and TennCare has determined that no other MCO is willing to serve the member. | |
| **Benefit Design** | Physical health services, behavioral health services, and long-term services and supports, ECF CHOICES HCBS (which are limited based on eligibility group).<br><br>Pharmacy services are carved out, but MCOs are responsible for maintaining an agreement with TennCare's selected pharmacy benefit manager to make payments on behalf of TennCare covered services, as well as monitoring and coordinating pharmacy utilization.<br><br>ECF CHOICES consumer-directed HCBS include:<br><br>• Personal assistance | 2.6.1.6.3<br>2.6.1.6.9<br>2.6.5.2.2<br>2.9.6.3.20<br>2.9.6.3.22 |

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| | • Supportive home care<br>• Hourly respite<br>• Community transportation<br>• Any other ECF CHOICES HCBS specified in TennCare rules as eligible for consumer direction which an ECF CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services<br><br>One-time ECF CHOICES HCBS include:<br><br>• Conservatorship and alternatives to conservatorship counseling and assistance<br>• Minor home modifications, (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) – Groups 4, 5, 6, 7 and 8<br>• Individual education and training services, (up to $500 per calendar year) – Groups 5, 6 and 8<br>• Specialized consultation and training, (up to $5,000 per calendar year) – Groups 5, 6 and 8<br>• Adult dental services, (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years) – Groups 4 (over 21), 5, 6 and 8<br>• Community support development, organization and navigation – Groups 4 and 7<br>• Family caregiver education and training, (up to $500 per calendar year) – Groups 4 and 7<br>• Assistive technology – Groups 4, 5, 6, 7 and 8<br>• Adaptive equipment and supplies<br>• Peer-to-peer support and navigation for person centered planning, self-direction, integrated employment/self employment, and independent community living, (up to $1,500 per lifetime) – Groups 5, 6 and 8<br>• Respite (up to 30 days per calendar year or up to 216 hours per calendar year only for persons living with unpaid family caregivers) – Groups 4, 5 and 6<br>• Family-to-family support – Groups 4 and 7<br>• Health insurance counseling/forms assistance (up to 15 hours per calendar year) – Groups 4 and 7<br>• Decision-making supports (up to $500 per lifetime) – Groups 4, 5, 6, 7 and 8<br>• Transition allowance – A one-time transition allowance, per member not to exceed $2,000, which can be used for rent, security deposits and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes. For members transitioning to provider-owned settings, the allowance can be used for household items and furnishings that are for the member's personal use.<br><br>Ongoing ECF CHOICE HCBS include: | |

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| | • Supportive home care – Group 4<br>• Intensive behavioral family-centered treatment, stabilization and supports (IBFCTSS) – Group 8<br>• Family caregiver stipend in lieu of supportive home care, (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older) – Group 4<br>• Independent living skills training, (subject to limitations specified in the approved 1115 waiver and TennCare rule) – Groups 4, 5, 6 and 7<br>• Community integration support services, (subject to limitations specified in the approved 1115 waiver and TennCare rule) – Groups 4, 5, 6 and 7<br>• Personal assistance, (up to 215 hours per month) – Groups 5 and 6<br>• Community transportation – Groups 4, 5, 6 and 7<br>• Community living supports (CLS) – Groups 5 and 6<br>• Community living supports family model (CLS-FM) – Groups 5 and 6<br>• Intensive behavioral community transition and stabilization services – Group 7<br>• Employment services and supports (subject to limitations specified in the approved 1115 waiver and in TennCare rule) – Groups 4, 5, 6, 7 and 8<br><br>ECF CHOICES HCBS benefits are subject to annual per member cap:<br><br>• Group 4 - $15,000, not counting the cost of minor home modifications<br>• Group 5 - $30,000, with an exception for emergency needs up to $6,000 in additional services per year but must not permit expenditures to exceed a hard cap of $36,000 per calendar year, except that, for purposes of compliance with the federal HCBS Settings Rule, a member receiving community living supports (CLS) may be permitted to exceed the cap when necessary to permit access to supported employment and/or individual employment support benefits. For a member requiring a community stabilization and transition rate of reimbursement for CLS, the higher cost of transitional CLS must be excluded from the Group 5 member's expenditure cap for the year in which the transitional CLS are required, when a member is expected to be safely and appropriately served within the expenditure cap, once transition to the appropriate ongoing CLS level occurs and the transitional rate ends.<br>• Group 6<br>  ○ Individuals in Group 6 with low need (as determined by the state) are subject to a $45,000 expenditure cap. The state may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to $7,500 per calendar year. Except as provided below, plan must not permit HCBS expenditures to exceed a hard cap of $52,500 per calendar year.<br>  ○ Individuals in Group 6 with moderate need as determined by the state are subject to a $67,500 expenditure cap. The | |

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| | state may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to $7,500 per calendar year. Except as provided below, plan must not permit HCBS expenditures to exceed a hard cap of $75,000 per calendar year.<br>▪ For purposes of compliance with the federal HCBS Settings Rule, a member receiving CLS may be permitted to exceed the $75,000 hard cap when necessary to permit access to supported employment and/or individual employment support benefits.<br>○ Individuals with high need (as determined by the state) are subject to a $88,250 expenditure cap. The state may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to $7,500 per calendar year. Except as provided below, plan must not permit HCBS expenditures to exceed a hard cap of $95,750 per calendar year.<br>▪ The state may grant an exception as follows: for individuals with DD and exceptional medical/behavioral needs (as determined by the state), up to the average cost of NF plus specialized services that would be needed for persons with such needs determined appropriate for NF placement; or for individuals with ID and exceptional medical/behavioral needs as determined by the state, up to the average cost of private ICF/IID services.<br>○ If a member is seeking to access ECF CHOICES HCBS through enrollment in ECF CHOICES Group 6 and the enrollment target for the group has been reached, the MCO may, subject to established eligibility and enrollment criteria, elect to enroll the person into CHOICES Group 2 or ECF CHOICES Group 6, as applicable, as a cost-effective alternative if the person is currently receiving nursing facility services or would be imminently placed in a nursing facility.<br>○ If a person is processed for enrollment in an available slot in ECF CHOICES Group 5 and is determined to meet NF LOC for reasons other than a safety determination, and a slot is not available in ECF CHOICES Group 6, the MCO must offer the person the choice of enrolling in ECF CHOICES Group 5, so long as his or her needs can be safely met with the array of benefits available if enrolled in Group 5.<br>• Group 7 – Is subject to an expenditure cap based on the comparable cost of institutional care as determined by TennCare. Any home health or private duty nursing services the member receives must be counted against the expenditure cap. While integrated in the delivery system, behavioral health services (other than IBFCTSS) are not to be counted against the expenditure cap. No exceptions to the expenditure cap are permitted for individuals in ECF CHOICES Group 7.<br>• Group 8 – Is subject to an expenditure cap based on the comparable cost of institutional care, as determined by TennCare, which may as determined appropriate, take into account the cost of short-term inpatient psychiatric hospitalization or other restrictive treatment setting for which the MCO would otherwise be responsible for payment. Any home health or private duty nursing services the member receives are not counted against the expenditure cap. While integrated in the delivery system, behavioral health services (other than IBCTSS) will not be counted against the expenditure cap. No exceptions to the expenditure cap must be permitted for individuals in ECF CHOICES Group 8.<br>• However, for all groups, MCOs can offer ECF CHOICE HCBS in excess of the benefit limits to ECF CHOICE members who meet NF | |

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| | LOC as a cost effective alternative to nursing facility care.<br><br>MCOs can offer non-covered HCBS to ECF CHOICES members who meet the nursing facility level of care upon written prior approval from TennCare. | |
| **Plan Type** | Traditional MCOs that offer coverage statewide. | A.2.2.1 |
| **Integration with Medicare** | MCOs are responsible for ensuring that covered services provided to dual eligibles are delivered without charge to members.<br><br>MCOs must coordinate with Medicare payors, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.<br><br>• MCOs must have policies and procedures on coordination and timely access to Medicare benefits for dual eligible members.<br>• Plans must coordinate with D-SNPs on discharge planning.<br>• MCOs must request, when appropriate, participation of the D-SNP in the comprehensive assessment and/or person-centered service plan (PCSP) development for ECF CHOICES member and, when the D-SNP does participate, forward the PCSP (and any updates to it) to the D-SNP within two days.<br>• MCOs must provide training to the D-SNP on its role in care coordination of Medicaid and Medicare services.<br>• Plans must work with TennCare to align, whenever possible, enrollment of dual eligible members in the same plan for both Medicare and Medicaid services and must have IT systems capable of accepting Medicare enrollments and loading enrollment data into its case managements system for use by support coordinators and case management, DM/population health and UM staff.<br><br>Plans are required to operate a D-SNP in each of the counties in Tennessee and must coordinate Medicare as well as Medicaid benefits for all dual eligible members. | A.2.2.5<br>2.9.6.3.27.11.4<br>A.2.9.13 |
| **Residential Services** | Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or alternative to an ICF/IID provided through a Home and Community Based Services (HCBS) waiver for persons with intellectual disabilities are carved out of managed care. However, MCOs are responsible for delivering covered services to members residing in an ICF/IID that are not included in the per diem reimbursement for institutional services (e.g., certain items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation) and must coordinate the delivery of these services with the ICF/IID to minimize disruption and duplication of services.<br><br>MCOs do cover nursing facilities and community-based residential alternatives (CBRAs) to institutional care. CBRAs are residential services that offer a cost-effective, community-based alternative to NF care for individuals with I/DD. CBRAs include services provided in a licensed facility such as assisted care living facilities and critical adult care homes, and residential services provided in a licensed home or in the person's home by an appropriately licensed provider such as community living supports and community living supports-family model; and companion care. CBRA services can only be authorized when the service and setting have been selected by the | Definitions<br>2.9.6.3.27.6<br>2.9.6.9<br>2.9.15 |

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| | member. For members moving into a CBRA, MCOs must review and approve the CBRA to ensure that the member's needs can be safely met and the support coordinator must visit the member after he or she moves in to ensure that they are satisfied and safe in the CBRA.<br><br>*Continuity of care for residential members*—For members in ECF CHOICES receiving nursing facility or CBRA services from a participating provider, MCOs must authorize such services from the current provider as of the effective date of enrollment and cannot move the member unless: (1) the member or his or her representative specifically requests to move; (2) the member or his or her representative provides written consent to move based on quality or other concerns (not reimbursement related) raised by the MCO; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the MCO must provide continuation of services in such facility for at least 30 days, which must be extended as necessary to ensure continuity of care pending the facility's contracting with the MCO or the member's transition to a contract facility; if the member is transitioned to a contract facility, the MCO facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the MCO must (a) authorize continuation of the services pending enrollment of the facility as a contract provider; (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations. | |
| **Care Coordination Model** | *Support coordination*—MCOs are required to provide comprehensive, holistic and person-centered support coordination to all ECF CHOICES members and other TennCare members in order to determine eligibility for and facilitate enrollment in TennCare ECF CHOICES.<br><br>• Support coordination should provide a continuous process for:<br>  ○ Identifying, developing, and supporting opportunities for a member's community involvement, including achieving and maintaining competitive, integrated employment consistent with the member's individual strengths, preferences and conditions for success;<br>  ○ Leveraging member strengths, resources and opportunities available in the community, and natural supports available to the member in coordination with ECF CHOICES services and supports to enable the member to achieve his or her desired lifestyle and goals;<br>  ○ Assessing a member's physical, behavioral, functional, and psychosocial needs;<br>  ○ Identifying the physical health, behavioral health and long-term services and other support services and assistance that are necessary to enable the member to achieve his or her desired lifestyle and goals;<br>  ○ Ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term services and supports necessary to facilitate the member's community involvement, including achieving and maintaining competitive, integrated employment, consistent with the member's individual strengths, preferences and conditions for success and necessary to maintain or improve his or her physical or behavioral health status and | 2.9.2.1<br>2.9.6.2.5.3<br>2.9.6.1<br>2.9.6.4<br>2.9.6.10.2,<br>2.9.6.2.5.3.2<br>2.9.6.2.5.12<br>2.9.6.10.3<br>2.9.6.2.5<br>2.9.6.3.15<br>2.9.6.3.16<br>2.9.6.3.19<br>2.9.6.3.26<br>2.9.6.3.27<br>2.9.6.5.2.5<br>2.9.6.5.2.6<br>2.9.6.6.2<br>2.9.6.7 |

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| | functional abilities, to maximize independence, to ensure the member's rights and choices, health, safety and welfare, and as applicable, to delay or prevent the need for more restrictive and more expensive institutional placement; and<br>○ Facilitating access to other support services and assistance the member needs to achieve his or her desired lifestyle, goals for community involvement, employment and independent living and wellness, and to address identified needs.<br>• MCOs are required to coordinate non-covered services and collaborate with community-based organizations to provide services that are important to the health, safety and well-being of members, including opportunities for employment.<br>• As part of support coordination, MCOs are required to assist the member as needed in completing a renewal packet and in gathering and submitting to TennCare the packet and any verification documents necessary for TennCare to determine ongoing financial eligibility.<br>• MCOs are required to monitor utilization data, including any available Medicare utilization, emergency department and behavioral health crisis services utilization data, to monitor members' outcomes and ensure that the member has the appropriate services in place to meet their needs.<br>• MCOs must have an electronic case management system that includes the functionality to ensure and document compliance with all requirements specified in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, the model contract, and TennCare policies and protocols.<br><br>*Support coordinator*—Support coordination is provided by a support coordinator that has primary responsibility for performance of support coordination activities, including for the member and contracted providers. MCOs have the option to use a team approach to support coordination, that must consist of the member's support coordinator and other individuals with relevant expertise and experience appropriate to address the needs of ECF CHOICES members; however, the support coordinator must remain the member's primary contact.<br><br>• Individuals enrolled in groups 7 and 8 must receive care coordination through an integrated support coordination team (IST) that includes the member's support coordinator and the behavior supports director (or a similarly qualified behavior supports professional, who must be responsible for performing in close collaboration the required support coordination functions).<br>• Members must be assigned a service coordinator either prior to the face-to-face visits (those who are receiving services in a nursing facility or a community-based residential alternative), or prior to the initiation of services, but no later than 10 calendar days following ECF CHOICES enrollment (those who are not receiving services in a nursing facility or a community-based residential alternative).<br>• Tennessee has established certain requirements to ensure that the support coordinator can adequately communicate with the member. The support coordinator must be competent in the member and primary caregiver's spoken language, sign language or other non-verbal forms of communication, including the use of assistive technology and auxiliary aids or services, as applicable. If the MCO cannot provide a competent service coordinator, it must ensure the availability of translation services.<br>• MCOs must provide direct telephone access to assigned support coordinators and, if the support coordinator is not available, | 2.9.6.12<br>2.9.7.9.2 |

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| | ensure that the call is answered by another qualified staff person in the support coordination unit and transferred directly to the support coordinator if it requires immediate attention.<br>• Members must be allowed change support coordinators if another is available, but can impose a six month lock-in period after the member has been granted a change, provided there is a for-cause exemption available.<br>• MCOs must minimize changes to support coordinators and have a process to notify members of changes in support coordinators.<br>• MCOs must engage in comprehensive training at the time of hire on various aspects of the ECF CHOICES program and Medicaid and Medicare generally, the role of the support coordinator, health, safety and welfare for individuals with I/DD, challenges faced by individuals with I/DD, person-centered practices and disability awareness and cultural competency. MCOs must also establish ongoing training.<br>• Qualifications:<br>  ○ Support coordinators must:<br>  ▪ Be an RN or LPN, with a preference that such individuals also have current certification from the Developmental Disabilities Nurses Association as a Certified Developmental Disabilities Nurse (CDDN) for RNs or a Developmental Disabilities Nurse (DDC) for LPNs;<br>  ▪ Have a bachelor's degree in social work, nursing, education, rehabilitation counseling, or other human service (e.g., psychology, sociology) or health care profession or other related field, as approved by TennCare;<br>  ▪ Meet the federal requirements for a Qualified Developmental Disabilities Professional (QDDP) or Qualified Intellectual Disabilities Professional (QIDP); or<br>  ▪ Have five or more years' experience as an independent support coordinator or case manager for service recipients in a 1915 (c) HCBS waiver and have completed certain trainings as established by the Council on Quality and Leadership and are prior approved by TennCare on a case-by-case basis.<br>  ○ Support coordinators supervisors must be a licensed social worker, registered nurse, or QDDP/QIDP with a minimum of two years of relevant health care case management (preferably long-term care) experience which must include case management for individuals with I/DD.<br>  ○ If the MCO is using a support coordination team, the MCO's policies and procedures must specify the qualifications, experience and training of each member of the team and ensure that functions specific to the assigned support coordinator are performed by the member's support coordinator.<br>• Caseload limits:<br>  ○ Average weighted caseloads must be no more than 1:115<br>  ○ Maximum weighted caseloads must be no more than 1:165<br>  ○ ECF CHOICES groups are weighted depending on group and residential setting, so caseloads for ECF CHOICES members are in reality much lower. | |

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| | ○ Failure to comply with these requirements will result in the MCO receiving double fines.<br><br>*Timeframes for support coordination*—The support coordinator must conduct a face-to-face visit with the member, initiate a comprehensive assessment that identifies strengths, needs, opportunities, and challenges, conduct a caregiver assessment, develop the PCSP and authorize and initiate services provided for in the PCSP within 30 days of enrollment, unless the member elects to participate in consumer direction or the member requests additional time to complete the process. If the MCO cannot initiate any LTC services within the timeframe required by TennCare, it must issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay and the date the service(s) will start, and must make good faith efforts to ensure that services are provided as soon as practical.<br><br>• However, if a plan becomes aware of an increase in a member's need prior to conducting the comprehensive assessment, the support coordinator must immediately conduct an assessment and update the plan of care within 10 days of such awareness.<br>• For Groups 7 and 8, the supportive home care component of the IBFCTSS benefit must be initiated as soon as possible, but no more than 60 days following effective date of enrollment in Group 7, so long as other covered benefits or cost-effective alternative services are provided in the home to ensure the person's needs are met.<br>• MCOs are required to determine if the member immediately needs any ECF CHOICES HCBS while the comprehensive PCSP is developed and authorize immediately needed services within 10 days. Immediate need is defined as services that a person needs in order to facilitate a timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting, to prevent imminent placement outside the person's current living arrangement, to address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm, or consistent with the program's primary goals, to prevent imminent loss of competitive integrated employment or an offer of such employment.<br><br>*Initial enrollment visit*—A face-to-face enrollment visit must be completed within five business days, unless otherwise specified by TennCare, of determination to proceed with enrollment of applicant into ECF CHOICES. As part of the enrollment visit for ECF CHOICES, MCOS must: (1) confirm or update, as applicable, the member's current address and phone number(s); (2) review ECF CHOICES education and information and assist in answering any questions the applicant may have; (3) make sure the member is aware that the Department of Intellectual and Developmental Disabilities (DIDD) policy does not permit a person enrolled in ECF CHOICES to enroll in the family support program operated by DIDD; (4) complete the level of care (i.e., PAE) application and provide assistance, as necessary, in gathering documentation needed by the state to determine eligibility for reimbursement of LTSS; (5) provide information about estate recovery; (6) provide detailed information and obtain signed acknowledgement of understanding regarding an ECF CHOICES member's responsibility with respect to payment of patient liability amounts, including the potential consequences for non-payment of patient liability; (7) provide information regarding consumer direction; and (8) provide information regarding next steps in the process including the need for approval by TennCare to enroll in ECF CHOICES and the functions of the MCO, including that the | |

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| | MCO will work with the applicant to develop and approve a PCSP.<br>• MCOs may, at their discretion, initiate the comprehensive assessment and determine immediately needed services as part of the face-to-face intake/enrollment visit for ECF CHOICES.<br>• As part of the face-to-face visit, the support coordinator must verify the member's interest in participating in consumer direction and provide information on participating providers that are able to serve the member.<br><br>*Comprehensive assessment*—MCOs are required to conduct a face-to-face assessment (which can be combined with the enrollment meeting) to inform development of the PCSP upon enrollment, annually thereafter, as otherwise deemed necessary by the support coordinator and within five business days of becoming aware that the member has a significant change in needs or circumstances.[5]<br><br>• At minimum, for members in ECF CHOICES, the comprehensive assessment must assess: (1) the member's strengths; (2) the natural and community supports (both currently involved and yet to be involved) available to the member, and the extent of the stability of each of those supports; (3) the member's preferences for lifestyle, employment, daily routine and community involvement, privacy, and direct support professionals; (4) the member's goals and needs related to: achieving his/her desired lifestyle and personal goals (including employment and community involvement goals); achieving and maintaining the best possible health and wellness; preserving and building natural and community supports; developing and maintaining a network of chosen and positive relationships; building skills and strategies for independence; achieving the greatest possible financial capabilities to maximize the member's ability to control personal income and other financial resources; understanding and exercising his/her rights, preserving guardianship of self, executing advance directives, utilizing durable power of attorney and/or power of attorney for health care; obtaining and maintaining safe, stable and affordable housing; building and preserving financial health; and mitigating risks associated with the member's desired lifestyle, chosen relationships, housing situation and/or impact of disability; (5) the member's overall wellness including physical, behavioral, functional, and psychosocial needs; (6) on-going clinical and/or functional conditions that may require intervention, a course of treatment and/or on-going monitoring; (7) any vulnerability and risk factors for abuse and neglect in the member's personal life or finances; (8) services or assistance programs the member may be receiving, may have access to and/or may be eligible for, in addition to, or in lieu of, services available through ECF CHOICES; and (9) supports, services, or items necessary to enable the member to achieve his/her preferred lifestyle and goals, to ensure community living, to facilitate gainful integrated employment, and to delay or prevent a decline in level of independence and functioning.<br>• The comprehensive assessment must determine how natural and community supports available to the member can best be coordinated and supported through the ECF CHOICES program. | |

[5] Significant change in needs or circumstances is defined as change of residence or primary caregiver or loss of essential social supports, significant change in physical or behavioral health and/or functional status, including any change that results in the member's level of care and transition between ECF CHOICES Groups, loss of mobility, an event that significantly increases the perceived risk to a member, member has been referred to APS or DCS, as applicable, because of abuse, neglect or exploitation; or loss of employment or change in employment status.

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| | • The comprehensive assessment must include exploration with the member of the member's understanding of consumer direction and any desire to self-manage all or part of services available through consumer direction as specified in the PCSP.<br><br>*Caregiver assessment*—The support coordinator must conduct a caregiver assessment as part of the face-to-face visit with new members in ECF CHOICES or the enrollment visit for current members and then annually thereafter, upon a significant change in circumstances or as the support coordinator deems necessary.<br><br>• The caregiver assessment must include: (1) an overall assessment of the family members and/or caregivers providing services to the member to determine the willingness and ability of the family members or caregivers to contribute effectively to the needs of the member, including employment status and schedule, and other care-giving responsibilities (2) an assessment of the caregiver's own health and well-being, including medical, behavioral, or physical limitations as it relates to the caregiver's ability to support the member; (3) an assessment of the caregiver's level of stress related to caregiving responsibilities and any feelings of being overwhelmed; (4) identification of the caregiver's needs for training in knowledge and skills in assisting the person needing care; and (5) identification of any service and support needs to be better prepared for their care-giving role.<br><br>*Visits in general*—MCOs must conduct a face-to-face visit to conduct a comprehensive assessment, conduct a caregiver assessment, and authorize and initiate ECF CHOICES HCBS. When conducting a face-to-face visit, the service coordinator must observe and document the member's physical condition and environment (i.e. living situation) to ensure the member is safe. Visits must then occur, at a minimum, at the following intervals:<br><br>• Group 4 – In person or by phone quarterly; in the residence biannually<br>• Group 5 – In person or by phone monthly; in the residence quarterly<br>• Group 6<br>  ○ Those members assessed to have low to moderate need and not to have exceptional medical or behavioral needs: in person or by phone monthly; in residence bimonthly<br>  ○ Those members assessed high need or exceptional medical or behavioral needs: in residence monthly<br>• Group 7 and 8<br>  ○ During the first month of enrollment and the 30 days prior to and following transition out of the group: in person, by phone or other audio/visual communication at least weekly; a minimum of at least one weekly contact must continue until IBFCTSS services are in place and for at least the first two weeks following the initiation of IBFCTSS services; thereafter, in residence at least monthly<br>  ○ The member can request contacts more frequently<br>• A face-to-face visit to update the PCSP must occur after a member withdraws from consumer-directed services.<br>• The MCO must visit the member face-to-face within five business days of becoming aware that the member has a significant | |

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| | change in needs or circumstances.<br><br>*Development of the PCSP*—MCOs are required to develop a written PCSP that documents the decisions made by the support planning team and identifies all ECF CHOICES HCBS that are needed, including those services that are immediately needed upon enrollment or other covered benefits or cost-effective alternative services to address immediate needs and those services that are needed to help members achieve their goals across all domains of the PCSP. The plan must be updated as needed, but must be reviewed no less than annually.<br><br>• The person centered service process must ensure that the employment informed choice process is initiated *(see Employment section below).*<br>• In order to develop the PCSP, the support coordinator must coordinate and facilitate a support planning team that includes the member, anyone chosen by the member to participate and the support coordinator. The support coordinator must seek input from other individuals such as the member's representative or other persons authorized by the member to assist with comprehensive assessment and care planning activities and must consult with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed. For members enrolled in ECF CHOICES Groups 7 or 8, person-centered planning processes must be conducted by the integrated support coordination team.<br>• PCSPs must include the following:<br>  ○ Member's information (address, phone number, authorized representatives)<br>  ○ Documentation that the setting in which the member resides is chosen by the member and meets the HCBS Settings Rule requirements<br>  ○ The member's strengths and interests<br>  ○ Person-centered goals and objectives, including employment (as applicable) and integrated community living goals, and desired wellness, health, functional, and quality of life outcomes for the member, and how ECF CHOICES services are intended to help the member achieve these goals<br>  ○ Risk factors for the member, which takes into consideration the member's decision to self-direct, if applicable, and measures in place to minimize them (including a medication risk assessment)<br>  ○ Support, including specific tasks and functions, that will be performed by family members and other caregivers<br>  ○ Caregiver training or supports identified through the caregiver assessment that are needed to support and sustain the caregiver's ability to provide care for the member<br>  ○ Home health, private duty nursing, and long-term care services the member will receive from other payor sources and from the MCO<br>  ○ ECF CHOICES HCBS that will be authorized, including the amount, frequency, duration, and scope of each service to be provided and how such services should be delivered, including the member's preferences for delivery<br>  ○ A detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as | |

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| | scheduled (for members self-directing, the support coordinator must develop and review with the member a back-up plan)<br>○ Description of the member's overall wellness, current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the member's physical, behavioral and functional needs<br>○ Description of the member's physical environment and any modifications necessary to ensure the member's health and safety<br>○ Description of medical equipment used or needed by the member<br>○ The primary language spoken by the member and/or his or her primary caregiver, or the use of other means of effective communication<br>○ A description of the member's psychosocial needs, including any housing or financial assistance needs which could impact the member's ability to maintain a safe and healthy living environment and how such needs will be addressed in order to ensure the member's ability to live safely in the community<br>○ For persons receiving CBRA services other than companion care, a description of the member's capabilities and desires regarding personal funds management; the extent to which personal funds will be managed by the provider agency or the member's representative (as applicable); whether the member will have a separate bank account rather than an agency-controlled account for personal funds; any training or assistance that will be provided to support the member in managing personal funds or to develop skills needed to increase independence with managing personal funds; goals and objectives involving use of the member's personal funds; and any health, safety or exploitation issues that require limitations on the member's access to personal funds and strategies to remove limitations at the earliest possible time<br>○ A person-centered statement of goals, objectives and desired wellness, health, functional and quality of life outcomes for the member and how ECF CHOICES services are intended to help the member achieve these goals<br>○ Description of other services that will be provided to the member<br>○ Relevant information regarding the member's physical health condition(s), including treatment and medication regimen, that is needed by a long-term care provider, caregiver or the support coordinator to ensure appropriate delivery of services or coordination of care<br>○ Frequency of planned support coordinator contacts needed<br>○ Additional information for members who elect consumer direction of eligible ECF CHOICES HCBS, including but not limited to whether the member requires a representative to participate in consumer direction and the specific services that will be consumer directed<br>○ A disaster preparedness plan, including any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol and identify any additional steps the member and/or representative should take in the event of an emergency<br>○ The member's TennCare eligibility end date | |

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| | ○ An attachment listing all of the member's current LTSS providers, updated when there is a change in LTSS provider<br>• The PCSP, as well as any updates, must generally be reviewed, signed and dated by the member or his or her representative and the support coordinator. It may only be signed electronically when the MCO has completed or updated the PCSP via a face-to-face visit.<br>• The MCO has to develop procedures for instances where the member refuses to sign the PCSP, which includes a review of the reasons for the member's refusal as well as actions taken to resolve any disagreements with the PCSP. If the refusal is a result of the member's desire for more services, the MCO must begin or continue services as provided in the PCSP while the issue is resolved.<br>• As part of the annual PCSP review the support coordinator must assess each member's experience in receiving Medicaid HCBS using the Individual Experience Assessment (IEA).<br>• The MCO must provide a copy of the PCSP to the member the member's representative, as applicable, the member's community-based residential alternative provider (as applicable), and other service providers.<br>• The member's support coordinator or support coordination team must further require that: (a) each provider signs the plan of care or PCSP, as applicable, indicating they have reviewed it in its entirety, they understand and agree to provide the services as described and in accordance with the specific goals, preferences and needs of the member, as outlined in the plan of care or PCSP, as applicable and the comprehensive assessment; and (b) each provider receives the fully completed comprehensive assessment and plan of care or PCSP, as applicable, at least two business days prior to the scheduled implementation of services and prior to any change in such services in order to ensure appropriate and timely training of provider staff.<br>• The PCSP must be updated within five business days of completion of the comprehensive assessment and provided to service providers within three business days of the update.<br>• For new services added to the PCSP, MCOs must provide information about potential providers of HCBS and assist members with choosing and changing providers.<br>• MCOs must put monitoring in place to ensure that services provided for in the PCSP are being delivered.<br>• Support coordinators must assess the PCSP by identifying and addressing gaps in care and risks to members.<br><br>*Selection of providers*—The support coordinator must, using current information regarding the MCO's network, provide member education regarding choice of contract providers for ECF CHOICES, subject to the provider's availability and willingness to timely deliver services, which must include information, as applicable, regarding providers who are able to assign staff who are linguistically competent in the member and/or primary caregiver's primary spoken language, or in sign language, or who can facilitate non-verbal forms of communication, including the use of assistive technology, as applicable, and the use of other auxiliary aids or services in order to achieve effective communication and obtain signed confirmation of the member's choice of contract providers.<br><br>*Nursing facility diversion and transition*—MCOs are required to have programs to help divert members from nursing home placements and to assist members who are currently in a nursing home and able and interested in transitioning back into to the community to do | |

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| | so safely. Tennessee places numerous requirements on MCOs to conduct transition assessments, make timely determinations, provide more intensive support coordination and ensure all supports and services are in place prior to transition from a nursing facility to the community.<br><br>*Monitoring of support coordination*—MCOs must have a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its support coordination processes. This includes ensuring that tools and protocols are applied consistently and objectively, timeframes for completion of support coordination activities and assessments are met, PCSPs are comprehensive and appropriate, services are appropriate and delivered timely and minimum support coordination contacts are conducted. MCOs are required to utilize electronic visit verification (EVV).<br><br>*Continuity of care*—MCOs are required to facilitate a seamless transition to new services and/or providers without and disruption in services.<br><br>• MCOs are prohibited from transitioning residents of nursing facilities or community-based residential alternatives unless the member consents or the member is residing in a facility that does not contract with the MCO. If the facility is a non-participating provider, the MCO must continue to authorize services as necessary to ensure a smooth transition.<br>• For members enrolling from another MCO, the two plans must work together to ensure a seamless transition of members. The receiving plan must continue to cover medically necessary services provided by the current providers (whether or not they are contracted with the receiving plan) without prior approval.<br>• For members with ongoing enrollment in ECF CHOICES, the MCO must continue the services for 30 days and cannot reduce services after that point unless the MCO has conducted a comprehensive needs assessment, developed a PCSP and authorized and initiated HCBS in accordance with the member's new PCSP.<br>• Where a member's provider has terminated participation with the MCO, the plan is required to assist members with transitioning to another provider. The MCO must ensure that there is no lapse in service and the provider continues to provide services until the member can be transitioned to another provider. | |
| **Staffing requirements** | MCOs are required to have:<br><br>• A full-time medical director exclusively for TennCare LTSS programs and services, including ECF CHOICES, who is a physician and has five years of experience in directing health care services for frail elderly or adults with physical disabilities, or people of any age with intellectual or developmental disabilities. The LTSS medical director is responsible for overseeing primary and physical health services provided to individuals receiving LTSS, and to comparable populations enrolled in TennCare, and all clinical activities pertaining to the operation of LTSS programs and services, including preventive care and the management and coordination of chronic conditions and physical health needs, and the integration and coordination of primary and other physical health services for members receiving LTSS. | |

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| | • A full-time behavior supports director dedicated exclusively to TennCare LTSS programs and services, including ECF CHOICES, who is a licensed psychologist with experience in applied behavior analysis or a board certified behavior analyst that has at least five years' experience directing behavior support services, including and at least two years' experience serving individuals with I/DD. The behavior supports director must oversee and be responsible for behavior support services provided to individuals receiving LTSS, and comparable populations.<br>• A full-time executive director dedicated to the ECF CHOICES program who has at least two years of experience administering managed long-term care programs and at least three years of experience administering LTSS for individuals with I/DD.<br>• A minimum of one dedicated ECF CHOICES lead trainer to develop and implement all ECF CHOICES staff training requirements.<br>• A full-time staff person dedicated to the ECF CHOICES program and part of the CHOICES management team who must be responsible for educating and assisting long-term care providers and the FEA regarding appropriate claims submission processes and requirements, coding updates, electronic claims transactions and electronic funds transfer; for the development and maintenance of CONTRACTOR resources such as ECF CHOICES provider manuals, website, fee schedules, etc.; for technical assistance regarding long-term care claims submission and resolution processes; and for prompt resolution of long-term care claims issues or inquiries.<br>• A full-time staff person dedicated to ECF CHOICES program who is a registered nurse or who has a master's degree in social work and has at least three years' experience providing person-centered support coordination to individuals with I/DD receiving LTSS and an additional two years' work experience in managed and/or long-term services and supports.<br>• Employed or contracted allied health professionals (including OT, PT, and SLP) as needed to participate as members of the interdisciplinary team to provide support and advisement to the ECF CHOICES support coordination lead.<br>• A specialized member advocate for individuals with intellectual or other types developmental disabilities in each grand region.<br>• A staff person dedicated to overseeing employment services and supports for LTSS programs and services with at least three years' experience in developing employment services and supports for persons with disabilities in integrated settings, which must include at least one year experience directing such programs and services; or other significant and relevant employment services expertise as approved by TennCare.<br>• A staff person dedicated to overseeing housing services and supports for LTSS programs and services that has at least three years' experience in assisting the elderly and persons with disabilities to secure accessible, affordable housing through federal and local programs including HUD subsidized housing and voucher programs, public housing authorities, and USDA's Rural Development Single Family and Multi-Family programs. | |
| **Dental Services** | Adult dental services are carved in, all other dental services carved out. The state's dental benefits manager (DBM) is responsible for developing a network of providers with I/DD experience to provide dental services to this population and is primarily responsible for coordinating delivery of dental services. However, MCOs are responsible for transportation to and from dental services, including dental benefits in ECF CHOICES, as well as the facility, medical and anesthesia services related to medically necessary and approved | 2.6.1.3<br>2.9.12.1<br>2.9.12.2 |

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| | dental services that are not provided by a dentist or in a dentist's office.<br><br>MCOs are required to coordinate with the DBM and/or the ID HCBS waiver contractor for dental services by establishing a process for the following:<br><br>• Referral for immediate access to emergency care and for the provision of urgent and routine care<br>• The transfer of information prior to and after the visit<br>• Resolving disputes related to prior authorization and claims and payment issues<br>• Cooperating with the DBM regarding training activities provided by the DBM<br>• Notifying the DBM when dental services have been approved, notifying the DBM when dental services have been approved as part of the PCSP, as well as the amount approved in the PCSP for such services<br>• Ensuring that the cost of dental services provided by the DBM are accounted for when determining the cost of ECF CHOICES HCBS provided to a member that must be counted against the member's expenditure cap<br><br>MCOs must establish claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the plan and form a joint claims coordination committee with the DBM to resolve disputes. For those not resolved by the committee, the issue is forwarded to the MCO's and the DBM's respective CEOs. Any issues that cannot be resolved by the MCO and DBM, are forwarded to TennCare for resolution. | |
| **Optical Services** | *Adult eye care*—Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), must be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.<br><br>*Adolescent eye care*—Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements. | 2.6.1.3 |
| **Workforce** | MCOs assist in developing an adequate qualified workforce for covered long-term services and supports by actively participating with TennCare, other MCOs, and other stakeholders as part of a statewide initiative to develop and implement strategies to increase the pool of available qualified direct support staff and to improve retention of qualified direct support staff. The strategies may include, for example, establishing partnerships with local colleges and technical training schools to develop and implement training and/or certification programs for direct support staff; providing incentives for providers who employ specially trained and/or certified staff and who assign staff based on member needs and preferences; and systems to encourage direct support staff to engage as an active participant in the care/support coordination team.<br><br>Tennessee leveraged a State Innovation Models initiative grant from the federal government to invest in the development and launch | 2.11.7.6<br>TennCare, 2018 Update to the Quarterly Assessment and Performance Improvement Strategy |

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| | of a comprehensive competency-based workforce training and development program for deployment through secondary and postsecondary vocational technical, trade schools, and community colleges. By offering college credit and a specialized certificate embedded in multiple degree paths, the program aims to provide an education path for direct support professionals, with opportunity to both learn and earn by acquiring shorter term, stackable credentials with clear labor market value that are recognized and portable across service settings. It also hopes to provide a career path for direct support professionals, as they continue to build competencies to access more advanced jobs and higher wages. A registry for search by individuals, families, providers and matching based on needs/interests of a person needing support will help to align competencies with member needs and interests, improving the overall member experience. TennCare partnered with the Tennessee higher education system to implement the Workforce Development training program through Tennessee's Colleges of Applied Technology and Community Colleges, awarding 18 hours of post-secondary credit and a post-secondary credential, and to leverage state last-dollar funding scholarship programs to cover the cost of the training for direct service workers. The training will be piloted through the end of 2018 and beginning of 2019, with anticipated implementation targeted in 2019. The direct support professional training programs consist of credentialing programs to support direct support workers with experience in the field as well as a pre and early training program to support workers who are new to the field. In addition, TennCare LTSS is developing programs to support self-direction of routine health care tasks, such as diabetes management and medication administration, with potential future trainings focusing on additional conditions or areas of expertise, such as dementia or specialized behavior support needs. | |
| **Plan Rates** | MCOs are paid a base capitation rate for each enrollee based on the enrollee's rate category. Rate categories are based on various factors, including the enrollee's enrollment in ECF CHOICES, category of aid, age/sex combination and region. Major aid categories include Medicaid, uninsured/uninsurable, disabled (the disabled rate is only for those enrollees who are eligible for Medicaid as a result of a disability), and duals/waiver duals (enrollees who have Medicare eligibility).<br><br>Adjustments to plan rates can only occur upon 30 days written notice from TennCare and followed up with an amendment to the model contract. If an MCO refuses to accept the rate but does not terminate the contract, the state can declare that a public exigency exists and pay the MCO under the new rates or terminate the contract and pay the MCO the new rate. TennCare can adjust rates retroactively if it is determined that an incorrect payment was made.<br><br>The state risk adjusts plan rates based on the health status information derived from encounter data during the most recent 12 month period determined by the state's actuary. TennCare calibrates health plan risk assessment scores on an ongoing basis for the purpose of monitoring shifts in enrollment and changes in program participation. If necessary, risk scores may be adjusted prior to the scheduled annual calibration.<br><br>For ECF CHOICES, plan rates include the following:<br><br>• Actuary and reasonable costs related to the provision of support coordination, subject to a maximum specified by TennCare | C.3.3<br>C.3.3.2<br>C.3.4.3<br>C.3.7.1<br>C.3.7.1.9<br>C.3.9<br>C.3.10.1<br>C.3.10.3 |

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| | • Actual and reasonable administrative costs related specifically to requirements for the operation of ECF CHOICES, subject to a maximum specified by TennCare<br>• The actual cost of ECF CHOICES HCBS and cost-effective alternative services provided under the ECF CHOICES program as a cost-effective alternative to NF services or to other ECF CHOICES services, in order to develop sufficient experience for purposes of establishing an actuarially sound capitation rate for ECF CHOICES HCBS<br><br>*Compliance withhold*—A withhold of the aggregate capitation payment must be applied to ensure MCO compliance with the requirements of the model contract and to provide an agreed incentive for assuring MCO compliance with the requirements of the model contract. The withhold is as follows:<br><br>• During the first six months of operations and for any consecutive six month period following the MCO's cure of a deficiency, 10%.<br>• During any consecutive six month period following the start date of operations where TennCare determines that the MCO has no deficiencies and has not issued a notice of deficiency, 5%.<br>• If, during any consecutive six month period following a reduction of the monthly withhold amount to 5%, TennCare determines that the MCO has no deficiencies and has not issued a notice of deficiency, 2.5%.<br>• If TennCare has not identified MCO deficiencies, TennCare will pay to the MCO the withheld in the month subsequent to which the withhold occurred.<br>• These funds may not be distributed to the MCO unless it is determined by TennCare that the MCO has come into compliance with the model contract requirements within six months of TennCare identifying these deficiencies.<br><br>*Pay-for-performance quality incentive*—The quality incentive uses the MCO's regional average HEDIS score for the last full calendar year prior to the year that the MCO began operating under the model contract (or the last year for which complete data is available) for each of the measures selected by TennCare as baseline. Quality incentive payments are made based on the MCO's performance relative to national benchmarks and its own baseline data. Incentive payments/penalties range from $0.02 to -$0.02 per member per month.<br><br>Wave 1 measures for measurement years 2019 and 2020 are:<br><br>• Timeliness of prenatal care;<br>• Postpartum care;<br>• Adolescent well-care visits;<br>• Diabetes-retinal exam and BP <140/90;<br>• Antidepressant medication management – continuation; | |

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| | Wave 2 measures for measurement years 2019, 2020 and 2021 are:<br>• Breast cancer screening;<br>• Immunization for children – combination 10<br>• Immunization for adolescents – combination 2<br>• Asthma medication ratio<br>• Follow-up after hospitalization for mental illness –within 7 days<br>• Engagement of alcohol and other drug abuse or dependence treatment | |
| **Value-Based Payment Arrangements** | Reimbursement for employment benefits reflects a variety of value-based approaches including outcome-based reimbursement for up-front services leading to employment, tiered outcome-based reimbursement for job development and self-employment start-up based on the member's "acuity" level and paid in phases to support tenure, and tiered reimbursement for job coaching also based on the member's acuity, but taking into account the length of time the person has held the job and the amount of paid support required as a percentage of hours worked (which helps to incentivize greater independence in the workplace, the development of natural supports, and the fading of paid supports over time).<br><br>Tennessee plans to implement value-based payment strategies to incentivize the provider adoption of practices that will lead to desired outcomes, including data collection, reporting, and use at the provider level and adoption of evidence-based and best practice approaches to workforce recruitment/retention as well as organization culture/business model changes. Incentives will also be aligned at the worker level by implementing pass through incentive payments to ensure wages are increased as direct support workers increase their level of training and competency and upon completing the certification program. VBP approaches will transition to financial incentives for specific workforce and quality of life outcomes once practices expected to result in the outcomes have been effectively adopted. The strategy will initially be implemented in ECF CHOICES; however, many providers participate across programs, thus spreading the impact of this work. Ultimately, the state intends to expand the approach across HCBS programs and authorities. | TennCare, 2018 Update to the Quarterly Assessment and Performance Improvement Strategy Mathematica, Serving Medicaid Beneficiaries Who Need Long-Term Services and Supports: Better Outcomes at Lower Cost |
| **Employment** | Employment services and supports include:<br>• Exploration,<br>• Discovery,<br>• Benefits counseling,<br>• Situational observation and assessment,<br>• Job development or self-employment plan,<br>• Job development or self-employment start up,<br>• Job coaching (including competitive, integrated employment and self-employment),<br>• Supported employment – small group, | Definitions<br>2.9.6.3.26.3.1 |

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| | • Co-worker supports,<br>• Career advancement,<br>• Integrated employment path services (time limited pre-vocational training).<br><br>The employment informed choice process includes, at minimum, an orientation to individualized integrated employment and individualized integrated self-employment, employment supports/services, vocational rehabilitation, and basic benefits/work incentives education provided by the member's support coordinator; the authorization and completion of exploration services in order to explore various employment options that are aligned with the member's interests, aptitudes, experiences and/or skills, to address concerns or questions, and ensure an informed choice regarding Individualized integrated employment and individualized integrated self-employment. Community integration support services and/or independent living skills training services can be authorized and on-going at the same time as the exploration service, up to a combined maximum of 20 hours per week. Upon completion of exploration services, if the member elects to pursue individualized integrated employment or individualized integrated self-employment, the support coordinator must proceed with authorization of the appropriate employment service(s) and/or referral to vocational rehabilitation; and community integration support services and/or independent living skills training may continue or begin, up to a maximum of 30 hours per week, when combined with and including at least one employment service. Upon completion of exploration services, if the member elects not to pursue individualized integrated employment or self-employment, a signed acknowledgement from the member/representative must be obtained to continue or begin receiving community integration support services and/or independent living skills training, up to a combined maximum of 20 hours per week.<br><br>When a member completes exploration, discovery, situational observation and assessment, or job development plan or self-employment plan, the service coordinator must contact the member within five days of completion of the service in order to initiate the next employment service needed. | |
| **Assistive Technology** | Assistive technology, adaptive equipment and supplies (up to $5,000 per calendar year) are available to members in all ECF CHOICES groups. | 2.6.1.6.3<br>2.6.1.6.3 |
| **Utilization Management** | MCOs must develop and maintain a utilization management (UM) program that is documented in writing, based on sound clinical evidence and reviewed and updated annually. MCOs may place appropriate limits on a covered benefit and establish procedures for medical necessity and the use of medically appropriate cost effective alternative benefits in accordance with the TennCare medical necessity rule.<br><br>*Personnel*—The UM program must assign responsibility to appropriate individuals including a designated senior physician and must involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. MCOs must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each | 2.6.3.1<br>2.6.3.2<br>2.14.1<br>2.14.5 |

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| | level of UM, including prior authorization and decision making.<br><br>*UM of LTSS*—MCOs must have an authorization process for covered long-term services and supports and cost effective alternative services that is separate from but integrated with the prior authorization process for covered physical health and behavioral health services. For ECF CHOICES, the MCO must include whether the HCBS or related service provide an opportunity for the member receiving long-term services and supports to have access to the benefits of community living, achieve person-centered goals, be free of undue restraint, and live and work in the setting of their choice.<br><br>MCOs must elicit pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. For ECF CHOICES HCBS which are not medical in nature, pertinent medical history must include assessments, case notes, and documentation of service delivery by HCBS providers. | |
| **Plan Selection** | Members can change once in the 90 days following enrollment (regardless of voluntary selection or auto-enrollment), after which they can only switch plans once every 12 months (the 90 day grace period applies to this enrollment as well). Members may appeal to TennCare to change MCOs based on hardship criteria. | 2.4.7.2 |
| **Enrollee Protections** | *Safety*—As part of the service coordination process and initial intake, MCOs are required to verify that a member's needs can be safely and effectively met in the community within the applicable expenditure caps.<br><br>*Reportable events*—MCOs must develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term services and supports service delivery setting, including: community-based residential alternatives; adult day care centers; other ECF CHOICES HCBS provider sites; and a member's home or any other community-based setting. Providers are required to notify MCOs of a reportable event, have supervisory staff review the event and determine the appropriate follow up. MCOS and providers must track and trend reportable events and evaluating such events to determine how to prevent or reduce similar occurrences in the future whenever possible and to report reportable events to TennCare and DIDD.<br><br>*Member services*—MCOs must have a phone line to respond to member questions, concerns, inquiries, and complaints, which must be staffed to answer member questions during normal business hours and to triage urgent care and emergency calls 24/7. Calls to the line that need to be addressed by the support coordinator must "warm transferred" directly to the support coordinator during normal business hours or responded to within 30 minutes during outside of normal business hours.<br><br>*Quality monitoring*—TennCare conducts quality monitoring of the MCOs' ECF CHOICES program, that includes:<br><br>• Quarterly and annual monitoring to ensure members are receiving appropriate population health, adequate and appropriate interventions based on stratification and setting.<br>• Quality of care is monitored through quarterly support coordination reports, annual quality assurance surveys and other ongoing monitoring. | 2.4.7.2<br>2.9.6.3.19.1<br>A.2.12.20<br>2.15.7<br>2.18.1<br>2.24.4 |

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| | • Quarterly monitoring to determine adherence with requirements for identifying, assessing, and transitioning ECF CHOICES members who may have the ability and/or desire to transition from a nursing facility to the community.<br>• Monthly monitoring regarding missed and late visits.<br>• Periodic case reviews to assess the comprehensive assessment and care and person-centered support planning processes.<br>• Quarterly monitoring of the MCO's provider network file.<br>• Annual monitoring of the MCO's long-term care provider network development plan.<br>• Quarterly monitoring of critical incidents and reportable events.<br>• Quarterly monitoring of the MCO's member complaints process to determine compliance with timeframes prescribed in the model contract and appropriateness of resolutions. | |
| **Advisory Committees** | *ECF CHOICES advisory group*—MCOs are required to establish a statewide ECF CHOICES advisory group to provide input and advice to the MCO's executive management and governing body and to TennCare regarding the health plan's ECF CHOICES program, policies and operation. The ECF CHOICES advisory group must have input on planning and delivery of long-term services and supports, ECF CHOICES QM/QI activities, program monitoring and evaluation, and member, family and provider education. MCOs are required to invite participation from several specified provider and advocacy groups, as well as members enrolled in ECF CHOICES. The advisory group must meet quarterly.<br><br>MCOs must work with the ECF CHOICES advisory group to convene community forums for individuals and families and for ECF CHOICES providers in each region on at least an annual basis in order to provide member, family and provider education, and to gather input and advice regarding the plan's ECF CHOICES program, policies and operation.<br><br>*Member-only advisory group*—MCOs must also establish a member-only advisory group composed exclusively of individuals with I/DD who participate in the ECF CHOICES program that meets quarterly. The member-only group must meet independently of the ECF CHOICES advisory group. Concerns from the member-only group should be elevated to the ECF CHOICES advisory group. | |
| **Network Adequacy** | When selecting providers, the MCO must take into account access and availability standards and may not discriminate against providers that service high risk populations or specialize in conditions that require costly treatment or on the basis of license or certification.<br><br>MCOs must have a provider network with adequate capacity to deliver covered physical and behavioral health services that meet the needs of persons with I/DD and must recruit and contract with physical and behavioral health care providers, in particular PCPs, who have the qualifications, capabilities and resources to work with persons with I/DD.<br><br>• MCOs must, in collaboration with DIDD, implement, distribute and train, and monitor PCPs and specialists regarding the use of best practice guidelines for acute and chronic conditions common to persons with I/DD, the unique needs of persons with I/DD, how to improve the quality of service delivery, and effective collaboration with persons with I/DD, their family members and | |

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| | conservators.<br><br>*Network adequacy standards—*<br><br>• CBRAs—MCOs must demonstrate good faith efforts to develop the capacity to have a travel distance of no more than 60 miles between a member's CBRA placement and the member's residence before entering the facility.<br>• ECF CHOICES HCBS—At least two providers per county; however, for HCBS provided in a member's place of residence, the provider does not need to be located in the county of the member's residence but must be willing and able to serve residents of that county. The network must be adequate to meet the needs of each and every ECF CHOICES member.<br><br>In developing a network of ECF CHOICES providers, MCOs must consider the following as "preferred contracting standards" for participating providers (but is not required to contract with all providers meeting this criteria or prohibited from contracting with providers who do not meet this criteria):<br><br>• The provider currently participates in one or more of the Section 1915(c) waiver programs for individuals with I/DD, and has a consistent quality assurance (QA) performance rating of "proficient" or "exceptional performance." Providers with "exceptional performance" must be given additional consideration.<br>• The provider has or is actively seeking (meaning applied for and has financially invested in the process) accreditation from a nationally recognized accrediting body, e.g., Commission on Accreditation of Rehabilitation Facilities (applicable only if accredited for the specific services the provider will provide in ECF CHOICES), Council on Quality and Leadership (CQL), and the Council On Accreditation (COA).<br>• The provider has a vocational rehabilitation letter of agreement with the Tennessee Department of Human Services, Division of Rehabilitation Services.<br>• The provider has completed DIDD person-centered organization training.<br>• The provider is START-Certified, or has completed START training.<br>• The provider has achieved documented success in helping individuals with I/DD achieve employment opportunities in integrated community settings at a competitive wage.<br>• The provider has demonstrated leadership in employment service delivery and community integration, e.g., designing and implementing plans to transition away from facility-based day services to integrated employment services with community-based wraparound supports.<br>• The provider can demonstrate longstanding community relationships that can be leveraged to assist members in pursuing and achieving employment and integrated community living goals, including commitments from community-based organizations and employers to work with the provider in order to help persons supported by the provider to achieve such goals.<br>• The provider has assisted persons supported by the agency in successfully transitioning into more independent living arrangements and also into arrangements that are not owned or controlled by a provider, and/or has experience facilitating | |

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| | home ownership for individuals.<br>• The provider has policies and systems in place to support member selection of staffing and consistent staffing assignment, which are implemented and monitored.<br>• The provider has capacity and willingness to function as a health partner with choice agency in order to support member participation in staff selection and supervision, including appropriate clinical and case management staffing to support ongoing assurance of appropriate preventive care and management of chronic conditions.<br>• The provider is willing and able to assign staff who are linguistically competent in spoken languages other than English that may be the primary language of individuals enrolled in ECF CHOICES and/or their primary caregivers. The provider is able to assign staff that are trained in the use of auxiliary aids or services in order to achieve effective communication with individuals enrolled in ECF CHOICES and/or their primary caregivers.<br>• The provider employs a certified work incentive coordinator (CWIC) who is available to counsel members on benefits and employment.<br>• The provider employs or contracts with appropriately licensed professionals in one (1) or more specialty areas (behavior services, occupational therapy, physical therapy, speech language pathology, nutrition, orientation and mobility, or nurse education, training and delegation) to assist paid staff in supporting individuals who have long-term intervention needs, consistent with the ISP, therefore increasing the effectiveness of the specialized therapy or service, and allows such professionals to be an integral part of the person-centered planning team, as needed, to participate in team meetings and provide additional intensive consultation for individuals whose functional, medical or behavioral needs are determined to be complex.<br>• The provider meets other standards established by TennCare in policy or protocol that are intended to confer preferred contracting status.<br><br>*Single case agreements*—If an MCO is unable to provide medically necessary covered services to a particular member using contracted providers, it must adequately and timely cover these services for that member using non-contract providers, for as long as the plan's provider network is unable to provide them.<br><br>*Network development plans*—MCOs must develop and maintain a network development plan to ensure the adequacy and sufficiency of its provider network, which must be submitted to TennCare annually, that includes the current network, monitoring activities, access trends, deficiencies and efforts to develop and enhance the network. | |
| **Provider Protections** | *Credentialing*—MCOs must work with TennCare and contracted providers to develop and implement a consolidated process for credentialing and recredentialing long-term services and supports providers, including ECF CHOICES, that seeks to minimize MCO and provider burden resulting from duplicative review processes when a provider is contracted with more than one MCO (the process must meet NCQA standards, as applicable). MCOs are not precluded from establishing and/or reviewing criteria that are unique from other | 2.11.1.1<br>2.11.1.9<br>2.11.7.4.1<br>2.11.7.4.2 |

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| | MCOs, but must seek to avoid duplicative review of criteria that are the same across MCOs.<br>• MCOs must develop policies that specify by HCBS provider type the credentialing process, the recredentialing process including frequency, and ongoing provider monitoring activities.<br>• Ongoing ECF CHOICES providers must be credentialed annually; all other ECF CHOICES HCBS providers must be recredentialed every three years.<br>*Contracting*—Provider contracts must meet specific requirements, including, but not limited to:<br>• Contracts must be in writing, inclusive of all terms agreed upon by the parties and specify the effective dates of the agreement.<br>• Contracts must be approved by TennCare.<br>• Contracts must identify the populations covered and the services and functions to be provide by the provider.<br>• Contracts must include provisions that require providers to comply with all applicable access requirements in the model contract and various member protections included in the model contract (i.e. no prior authorization for emergency services, prohibition on refusal to provide services to children under the age of 21 for non-medical reasons, etc.)<br>• Contracts must require that providers maintain documentation and medical records as required by law and the model contract.<br>• Contracts must require that providers participate in and cooperate with plan audits, oversight, corrective action plans, quality monitoring and improvement and utilization management programs.<br>• Contracts must provide a full disclosure of the method and amount of reimbursement, but cannot include rate methodology that provides for an automatic increase in rates.<br>• Contracts must require that, for ECF CHOICES members, the provider notify the support coordinator of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services as expeditiously as warranted by the member's circumstances.<br>• Contracts must include language that permits the MCO to suspend, deny, or refuse to renew or terminate any provider agreement in accordance with the terms of the model contract, applicable law and at the direction of TennCare.<br>• Contracts must require that ECF CHOICES HCBS providers notify MCO at least 30 days in advance when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the member's support coordinator to facilitate a seamless transition to alternate providers.<br>• Contracts must require that ECF CHOICES HCBS providers continue to provide services to a member transitioning to another provider until such transition occurs.<br>• Contracts with ECF CHOICES HCBS providers must specify that reimbursement is contingent upon the provision of services to an eligible member in accordance with applicable federal and state requirements and the member's PCSP and must be supported by detailed documentation of service delivery to support the amount of services billed.<br>• Contracts with ECF CHOICES HCBS providers must require to immediately report any deviations from a member's service | A.2.11.8<br>2.12.9<br>2.12.11<br>2.12.14<br>2.13.4<br>2.18.4<br>2.18.7<br>2.22.4 |

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| | schedule that would affect service authorizations to the member's support coordinator.<br>• Contracts with ECF CHOICES HCBS providers must require use of EVV and comply with the HCBS Settings Rule.<br>• Contracts with ECF CHOICES HCBS providers must prohibit these providers from soliciting members to receive services from the provider.<br>• Contracts with ECF CHOICES HCBS providers must require providers comply with critical incident and reportable event requirements and designate a staff member as an incident management coordinator.<br><br>*Reimbursement*—ECF CHOICES HCBS must be reimbursed at the rate set by TennCare. For other HCBS that are not otherwise covered but are offered by the MCO as a cost effective alternative to nursing facility services, the MCO is permitted to negotiate the rate of reimbursement.<br><br>*Timely submission of claims*—Providers must be given 120 days from the date of service to submit claims, expect in situations regarding coordination of benefits or subrogation.<br><br>*Prompt pay*—MCOs must pay 90% of all clean claims within 30 calendar days of receipt and must process and pay, if appropriate, 99.5% of all claims within 60 calendar days of receipt. MCOs must pay 90% of clean claims for ECF CHOICES HCBS within 14 calendar days of receipt and 99.5% of clean claims for ECF CHOICES HCBS within 21 calendar days of receipt.<br><br>*Claim disputes*—MCOs must have internal claims dispute procedures and independent reviewers to review disputed claims pursuant to TennCare provider independent review of disputed claims.<br><br>*Provider services*—MCOs must establish and maintain a provider services function to timely and adequately respond to provider questions, comments, and inquiries during normal business hours. MCOs are held to certain performance standards for their provider services lines that measure answer times, rate of abandonment and wait times.<br>• MCOs must provide one-on-one training to ECF CHOICES providers as needed to help them submit clean and accurate claims and minimize claims denial. MCOs must contact providers if the provider has a denial rate of more than 10% for a rolling 30 day period.<br>• MCOs must implement an annual satisfaction survey for ECF CHOICES providers to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, utilization management processes, including medical reviews, and overall satisfaction. | |
| **Telehealth** | TennCare generally provides reimbursement for telehealth (including real-time, synchronous communications and store and forward). | Tenn. Code Ann. § 56-7-1002 |
| **Self-Direction** | ECF CHOICES members may choose to participate in consumer direction of eligible ECF CHOICES HCBS, including personal assistance, | 2.6.1.6.1 |

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| | including supportive home care, respite, and community transportation and/or any other service specified in TennCare rules and regulations as available for consumer direction. At a minimum, self-direction allows members to hire, fire and supervise workers and determine how much workers are paid for these services.<br><br>• Members are able to, or have appointed by a guardian, designate a representative to assume the consumer direction responsibilities on his or her behalf.<br>• The support coordinator must verify the member's interest in participating in consumer direction annually and obtain written confirmation of the member's decision during development and review of the PCSP. Members are free to elect participation or withdraw from participation at any time.<br>• The MCO is responsible for determining the member's ability to self-direct and must notify the member if they require assistance to self-direct and inform the member that he or she will have to designate a representative to assume the consumer direction functions on his or her behalf.<br>• Once a member has elected to self-direct, the MCO must collaborate with the FEA to coordinate implementation and monitor delivery of self-directed services. Tennessee imposes specific timeframes for the MCO to make referrals, provide authorizations, and notify the FEA of any changes to the PCSP.<br><br>Members in ECF CHOICES must have modified budget authority. Once a budget has been established based on the member's needs and the units of service necessary to meet the member's needs, the budget for personal assistance or supportive home care services and a separate budget for community transportation services must be allocated on a monthly basis and the budget for respite services must be allocated on an annual basis.<br><br>*FEA*—The MCO must contract with an FEA to provide financial administration and supports brokerage functions.<br><br>*Training*<br><br>• MCOs must ensure that FEAs provide training to all members and/or their representatives in training on consumer-direction that includes the roles of members, their representatives, the FEAs and the MCO, being an employer (hiring, scheduling, approving timesheets, etc.), abuse and neglect reporting and fraud, waste and abuse prevention. Ongoing training is provided by the FEA.<br>• FEAs must also provide initial and ongoing training to all workers on the ECF CHOICES program, providing person-centered support, abuse and neglect reporting, fraud, waste and abuse prevention, critical incident and reportable event reporting, documentation and timekeeping and universal precautions and blood borne pathogens training.<br><br>*Monitoring*—The MCO must monitor consumer-directed services to ensure quality of service delivery and success for the member (plans are required note any patterns, such as frequent turnover of representatives or workers, habitual mismanagement of authorized services, failure to cooperate with the FEA and changing between consumer direction of eligible ECF CHOICES HCBS and contract | 2.7.3<br>2.9.6.10.2.1.2<br>2.9.6.11<br>2.9.7.1<br>2.9.7.2<br>2.9.7.4 |

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| | providers that may warrant intervention).<br><br>*Allegations of abuse*—If abuse or neglect are suspected, both the MCO and the FEA have an affirmative obligation to report the allegations to TennCare and to work with the member to replace the worker or representative if the allegation involves physical or sexual violence and/or the allegation is substantiated.<br><br>*Discontinuation of services*—MCOs are permitted to disenroll members, upon approval from TennCare, from consumer-directed services in limited circumstances, including if: (1) a member's representative fails to perform in accordance with the terms of the representative agreement and the health, safety and welfare of the member is at risk, and the member wants to continue to use the representative; (2) member has consistently demonstrated that he or she is unable to manage, with sufficient supports his or her services and the support coordinator or FEA has identified health, safety and/or welfare issues; (3) the support coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker. The member has the right to appeal this decision.<br><br>*Payment of claims*—MCOs are required to pay all FEA claims within 14 calendar days. | |
| **Additional Information** | MCOs are responsible for the delivery of medically necessary covered services to school-aged children and are encouraged to work with school-based providers to manage the care of students with special needs. With parental consent, MCOs may request Individualized Education Plans (IEPs) from the Department of Education and the school. | 2.9.16.7.1<br>2.29.1.3.4<br>2.29.1.3.7 |