Employment and Community First CHOICES (ECF CHOICES) provider orientation
Our mission and values

Our mission
The Amerigroup Community Care mission is to provide real solutions for members who need a little help by making the health care system work better while keeping it more affordable for taxpayers.

Our values
The Amerigroup values include:

• Compassion
• Quality
• Integrity
• Teamwork
• Respect for people
• Good citizenship
• Personal accountability
Training topics

- ECF CHOICES overview
- Screening
- ECF CHOICES benefits
- Non-ECF CHOICES benefits: Behavioral health
- Person-centered practices: Language, planning, patient-centered specialty practice (PCSP), provider role
- Home- and community-based services (HCBS) Settings
- Support coordination
- Service implementation plans
- Quality: Reportable events and quality monitoring
- Compliance and credentialing
- Claims and payments
- Support for providers
- Reference tools and provider website
ECF CHOICES
Transforming the system, transforming lives.

**Why we are here:**

- To make integrated employment and community living first in Tennessee by working together.
- Tennessee is the first state in the country to develop and implement a home- and community-based services (HCBS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent living as the first and preferred option for all individuals with intellectual and developmental disabilities (I/DD).
Who benefits from ECF CHOICES?
Those with I/DD who are not currently receiving services
(Note: Those currently with waivers are not impacted, but can choose to move to the program at a later time.)

What does the program offer?
• Support to help those with I/DD achieve employment and independent living goals
• Support for families caring for a person with I/DD
• Residential and day services to help those with complex needs live in the community and achieve their community living goals
(Note: ECF CHOICES is not intended to provide 24-hour supports, except for those assessed to need them.)
ECF CHOICES providers are a critical part of systemic, transformational change that will establish national benchmarks for other long-term services and supports programs for those with I/DD across the nation.

The ECF CHOICES provider network is the first in the country to develop an employment-first culture throughout all agencies.

The provider network:

- Raises expectations for supporting people with disabilities in obtaining meaningful, competitive employment.
- Supports and encourages individuals to be independent, vibrant members of their community.
- Empowers I/DD self-advocates.
Screening
Individuals must self-screen to determine ECF CHOICES eligibility by completing the screening tool on the TennCare website at https://tcreq.tn.gov/tmtrack/ecf/index.htm.

If individuals are unable to complete the self-screen or have no natural support to do so on their behalf, they may call Amerigroup at 1-866-840-4991 (TTY 711) to speak with trained agents who will assist.

Individuals who meet screening criteria will receive a face-to-face intake visit.

Enrollment into ECF CHOICES is determined by TennCare, and subject to availability of an appropriate slot for the person to enroll.
ECF CHOICES benefits
Benefits for ECF CHOICES members:

• Include an array of employment services and supports.
• Are designed in consultation with experts from the federal Office of Disability Employment Policy.
• Are intended to create a pathway to employment.
• Include wraparound services to support community integration.
• Include many services developed from stakeholder input that are intended to empower individuals and families toward independence and integration.
• Do not include facility-based services.
ECF CHOICES has a tiered benefit structure based on the needs of individuals enrolled in each group. This helps provide services in a cost-effective manner so that more people can be served over time.

**Three benefit groups:**
- Group 4: essential family supports
- Group 5: essential supports for employment and independent living
- Group 6: comprehensive supports for employment and community living
Benefits — Essential family supports benefit group (Group 4)

Group 4 eligibility:
• Families with children younger than 21 years of age with intellectual or developmental disabilities
• Those who meet nursing facility level of care, or who are at risk of institutionalization without HCBS
• Adults over 21 years of age living at home with family caregivers may elect to enroll in this group

Services/supports:
• Offers HCBS beyond the scope of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) that will help support families and sustain natural caregiving networks
• Helps with planning and preparing for transition into employment and integrated, independent living in adulthood
Group 5 eligibility:

• Adults older than 21 years of age with intellectual or developmental disabilities
• Those who are at risk of institutionalization without HCBS
• Young adults transitioning from school who are already employed in an integrated setting and received prioritized enrollment

Services/supports:

• Helps adults plan and achieve employment and independent living goals, as well as experience community life
• Helps young adults transition from school into integrated, competitive employment
Group 6 eligibility:
• Adults age 21 and older with intellectual or developmental disabilities who meet nursing facility level of care and require specialized supports related to I/DD (more significant needs)
• Families with aging caregivers receive prioritized enrollment

Services/supports:
• More intensive level of services/supports
• Helps adults plan and achieve employment and community living goals
• Helps adults become as independent as possible and participate fully in community life
## Benefits table

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Group 4: Essential family supports</th>
<th>Group 5: Essential supports for emp. and independent living</th>
<th>Group 6: Comprehensive supports for emp. and independent living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite (up to 30 days per calendar year or 216 hours per calendar year only for persons living with unpaid family caregivers)</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Supportive home care (SHC)</td>
<td>X</td>
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<tr>
<td>Family caregiver stipend in lieu of SHC (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community integration support services</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community transportation</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Independent living skills training</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assistive technology, adaptive equipment and supplies (up to $5,000 per calendar year)</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Minor home modifications (up to $6,000 per project, $10,000 per calendar year and $20,000 per lifetime)</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>
## Benefits table (cont.)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Group 4: Essential family supports</th>
<th>Group 5: Essential supports for emp. and independent living</th>
<th>Group 6: Comprehensive supports for emp. and independent living</th>
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</thead>
<tbody>
<tr>
<td>Community support development, organization and navigation</td>
<td>X</td>
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<tr>
<td>Family caregiver education and training (up to $500 per calendar year)</td>
<td>X</td>
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<tr>
<td>Family-to-family support</td>
<td>X</td>
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<tr>
<td>Conservatorship and alternatives to conservatorship counseling and assistance (up to $500 per lifetime)</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Health insurance counseling/forms assistance (up to 15 hours per calendar year)</td>
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<tr>
<td>Personal assistance (up to 215 hours per month)</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Community living supports (CLS)</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Community living supports — family model (CLS-FM)</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Individual education and training (up to $500 per calendar year)</td>
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<tr>
<td>Benefit</td>
<td>Group 4: Essential family supports</td>
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<td>Peer-to-peer support navigation for person-centered planning,</td>
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<td>self-direction, integrated employment/self-employment and</td>
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<td>independent community living (up to $1,500 per lifetime)</td>
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<td>Specialized consultation and training (up to $5,000 per calendar</td>
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<td>X</td>
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<td>year)</td>
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<tr>
<td>Adult dental services (up to $5,000 per calendar year; up to $7,500</td>
<td>X²</td>
<td>X</td>
<td>X</td>
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<td>across three consecutive calendar years)</td>
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<tr>
<td>Employment services/supports</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Supported employment: individual employment support</td>
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<tr>
<td>Exploration</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Benefit counseling</td>
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<td>Discovery</td>
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<tr>
<td>Situational observation and assessment</td>
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<tr>
<td>Job development plan or self-employment plan</td>
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<td>Job development or self-employment start up</td>
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<tr>
<td>Job coaching for individualized, integrated employment or self-</td>
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<td>employment</td>
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<tr>
<td>Coworker supports</td>
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<tr>
<td>Career advancement</td>
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</table>
1 For adults in Group 6 determined to have exceptional medical and/or behavioral support needs, specialized consultation services are limited to $10,000 per person per calendar year.
2 Limited to adults 21 years of age and older.
ECF CHOICES — Employment

• Employment is emphasized and supported in new and innovative ways.
• A full range of supports and services from exploration to employment customization is provided.
• Supports and services are individually designed to support employment goals and outcomes.
• Goals and outcomes for employment are developed using a person-centered planning process.
Employment services and supports

**Supported employment — Individual employment support includes:**

- Exploration
- Discovery
- Situational observation and assessment
- Job development plan or self-employment plan
- Job development or self-employment start-up
- Job coaching for individualized, integrated employment
- Job coaching for individualized, integrated self-employment
Supported employment — Individual employment support includes:

- Coworker supports
- Supported employment — small group
- Career advancement
  - Eligible for outcome payment after developing written plan to achieve the person’s career advancement objective
  - Second outcome payment available after the person has achieved specific career advancement objective and has been in a new position/job for two weeks
- Integrated employment path services
- Benefits counseling
Several services will be reimbursed on an outcome basis. These services and the requirements are as follows:

- **Exploration**: receipt/approval of written report summarizing process and outcomes
- **Discovery**: receipt/approval of written profile summarizing process, learning and recommendations for next steps
- **Situational observation and assessment**: receipt/approval of written report summarizing key learnings to inform job development or self-employment plan
- **Job development plan or self-employment plan**: receipt/approval of plan
- **Job development or self-employment start-up**: documentation that integrated, competitive employment or self-employment has begun
- **Career advancement**: receipt/approval of written career objective plan
ECF CHOICES — Individual services and supports

- Community integration support services
- Community transportation
- Independent living skills training
- Personal assistance
- Assistive technology, adaptive equipment and supplies
- Specialized consultation and training
- Minor home modifications
- Community living supports (CLS), and community living supports — family model (CLS-FM)
- Individual education and training
- Peer-to-peer support and navigation (for person-centered planning, self-direction, integrated employment/self-employment and independent community living)
- Adult dental services
ECF CHOICES — Family caregiver supports

- Supportive home care
- Family caregiver stipend
- Respite
- Family caregiver education and training
- Conservatorship counseling and assistance, as well as alternatives to conservatorship
- Health insurance counseling and forms assistance
- Family-to-family support
- Community support development, organization and navigation
Non-ECF CHOICES benefits: behavioral health
ECF CHOICES members have access to behavioral health services through their TennCare benefits.

All behavioral health services are delivered in a manner that supports the recovery of patients experiencing mental illness and enhances the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance and/or substance use disorders. Recovery is a patient-driven process in which patients are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life with a disability.
The following are covered fee-for-service outpatient behavioral health services:

- Outpatient therapy
- Applied behavioral analysis
- Psychiatric services (medication management)
- Crisis services
- Tennessee Health Link
- Psychosocial rehabilitation services
Person-centered practices
Person-centered language

- Person-centered language recognizes the impact of language on thoughts and actions.
- Person-centered language does not diminish the uniqueness and intrinsic value of each person and allows a full range of thoughts, feelings and experiences to be communicated.
- Person-centered language emphasizes the importance of a person’s cultural preferences and communication style when training a direct support professional on the person he or she will support.
Person-centered planning

- Person-centered planning is a process whereby the needs and preferences of the individual receiving services are described by that person — in collaboration with family, friends and other circle of support individuals — to develop a support plan that ensures the person receives the covered services they need in a manner they prefer.

- Planning is conducted to reflect what is important to the individual to ensure health, welfare and delivery of these services are in a manner reflecting personal preferences.
The purpose of person-centered planning is:

- To look at an individual in a different way.
- To assist a person in gaining control over his/her own life.
- To increase opportunities for participation in the community.
- To recognize individual desires, interests and dreams.
- To develop a plan that turns dreams into reality through a team effort.
Making person-centered planning successful

- Have a clear and shared appreciation of the skills and capacities of the person supported
- Meet regularly with the person and his or her key supports to review methods used or brainstorm different approaches
- Make meaningful connections to the local community
- Use the provided person-centered planning tools and create your own
- Motivate the person and his or her key supports to keep moving forward — Once initial goals are met, make new ones

This is an open process that continues throughout the individual’s lifetime (not a product)
Person-centered support plan (PCSP)

The *HCBS Settings Rule* includes the following changes to requirements regarding the PCSP:

- It must be developed through a person-centered planning process — driven by the individual and includes people chosen by the individual
- It provides necessary information and support to the individual — ensures that he or she directs the process to the maximum possible extent
- It is timely and occurs at times/locations of convenience to the individual
- It reflects cultural considerations/uses plain language
- It includes strategies for solving disagreement
- It offers choices to the individual regarding services and supports he or she receives and from whom
- It provides a method to request updates
PCSP (cont.)

- It is conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
- It identifies the strengths, preferences, needs (clinical and support) and desired outcomes of the individual.
- It may include whether and which services are self-directed.
- It includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, health care and wellness, education, etc.
- It includes risk factors and plans to minimize them.
- It is signed by all individuals and providers responsible for its implementation and a copy of the plan is provided to the individual and his or her representative.
For individuals supported in the ECF CHOICES program, the process for identifying and reviewing restrictions is contemplated in the PCSP development process and reviewed by the interdisciplinary team that manages the Amerigroup Settings Compliance Committee for ECF CHOICES and TennCare CHOICES (CHOICES). This committee is responsible for reviewing and approving all restrictions. If any restrictions are approved, it will be outlined in the HCBS Settings section of the PCSP. Providers interface closely with the Support Coordination team. Providers should notify the support coordinator of recommendations to implement or remove restrictions. Recommendations will be reviewed by the Settings Compliance Committee. If accepted, the PCSP will be updated to reflect the amendment to add or remove the restriction.
The PCSP is always evolving as the individual is also evolving.

- Interests and goals may change as the person integrates into the community and is exposed to more options.
- The PCSP will also change as a person’s service needs change.
- Providers play an important role in the evolution of the PCSP.
- Collaboration/communication between the provider and care coordinator/support coordinator is key to ensuring services and supports reflect the current needs, goals and interests of the person supported.
- As providers identify natural supports and/or if fading of services occurs, the PCSP will need updating to reflect the person’s current situation.
- Changes to a person’s health must also be reflected in the PCSP.
When accepting referrals for HCBS services, the provider must review the documentation provided in the referral and determine capacity to meet the person’s specific needs.

- Ensure qualified and trained staff are available and properly matched with the individual needing supports.
- Assess capacity to meet the person’s transportation needs (if applicable).
- Review cultural preferences and communication needs.
- Participate in meet-and-greets with the person.
- Sign and return the PCSP after receiving it to acknowledge you are ready to begin services.
- Accept and start services in a timely manner.
- Use the PCSP to develop an implementation plan.
- Ensure direct support professionals are trained on the PCSP and service implementation plan (if applicable).
HCBS Settings
Home- and community-based services (HCBS):

- Is integrated in and supports access to the greater community.
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.
- Ensures the person receives services in the community to the same degree of access as individuals not receiving Medicaid home- and community-based services.
- Is selected by the person from among setting options, including nondisability-specific settings and an option for a private unit in a residential setting.
Effective July 1, 2015, Amerigroup is required to verify that HCBS providers are in compliance with the *HCBS Settings Rule* detailed in 42 C.F.R. § 441.301(c) (4)-(5). We will verify provider compliance during the credentialing process, prior to executing an agreement with a provider, and during recredentialing. If a provider is not compliant with the *HCBS Settings Rule*, Amerigroup can not contract with the provider.

Intent of the final rule:

- To ensure that individuals receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and an opportunity to receive services in the most integrated setting appropriate

- To enhance the quality of HCBS and provide protections to participants
At a minimum, recredentialing HCBS providers includes:

- Verification of continued licensure and/or certification.
- Verification of compliance with policies and procedures identified during credentialing, including:
  - Background checks and training requirements.
  - Critical incident reporting and management.
  - Use of the electronic visit verification (EVV) system.

Amerigroup will use the HCBS audit process to monitor compliance with the Settings Rule and will complete HCBS annual audits that include evaluating physical location, policies, procedures and other written documentation, employee training, and employee files.
The Amerigroup Settings Compliance Committee for ECF CHOICES and CHOICES will review referrals provided from the support coordinators/care coordinator leadership and as part of their review they shall complete the following:

• Review any proposed or emergency right restrictions and restraints included and not included in a behavior support plan, PCSP or plan of care for potential human rights violations and ensure informed consent of any restriction

• Provide input for any modifications to members rights when the member resides in a provider owned or controlled residential setting prior to modification being included in member’s person-centered support plan

• Review potential violations to *HCBS Settings Rules* in instances in which a member is living in an unlicensed setting or licensed setting other than those covered in benefits for CHOICES and ECF CHOICES members, that may be in violation of *HCBS Settings Rules* and make recommendations for coming into compliance with *HCBS Settings Rules*
• Review the number of psychotropic medications being prescribed, including use of PRN psychotropic medication
• Review and make recommendations regarding complaints received pertaining to potential human rights violations
• Ensure that proposed restriction is the least restrictive viable alternative and is not excessive
• Ensure that proposed restriction is not for staff convenience
Support coordination
Every ECF CHOICES member is assigned a support coordinator. The support coordinator’s primary responsibility is to provide individualized member support through a coordinated, multidisciplinary approach that includes:

- Allocating appropriate resources
- Identifying community resources
- Coordinating care with community support agencies
- Monitoring compliance based on the member’s needs
- Member education
- Other resources as necessary for the member
The support coordinator:

• Gets to know the person and his or her supports, environment and goals.

• Develops the person-centered support plan document to:
  o Record a thorough and accurate history of the person (including physical, functional, behavioral, social and environmental factors).
  o Record what is important to the person and how best to support him or her.
  o Identify important people who are supporters in decision-making.
  o Provide a risk assessment determining if the person needs any restrictions.
  o Record important relationships and communication styles.

• Coordinates care with primary care/specialty providers and identifies wrap-around supports.
The support coordinator also:

- Initiates referrals that are informative for the provider to make a quick decision.
- Coordinates meet-and-greets.
- Ensures the person and his or her supporters are educated about the services they will receive.
- Develops close relationships with the provider supporting the person:
  - Notifies the provider if there will be a change in provider or services.
  - Assists the provider in receiving authorization to begin services.
  - Communicates with the provider and Provider Relations.
- Facilitates timely initiation of services outlined in the person-centered support plan.
- Helps the person to have *choice* in his or her benefits and within annual budget.
Authorization/notification requirements

Authorization is required for all ECF CHOICES services. Amerigroup will provide an authorization in accordance to the member’s PCSP. To request an authorization or change in the PCSP, please send an email to ltcprovreq@amerigroup.com and include the following information:

- Provider name/Amerigroup Provider ID
- Member name/Amerigroup Subscriber ID
- Dates of service/service/unit amount requested
- Member schedule (for services monitored through EVV)
Service implementation plan
Service implementation plan

The service implementation plan describes how the provider organization will support the person to achieve his or her goals. It is used in a manner to:

• Assure consistency between the person’s stated goals and provider-directed activities and staff support.

• Measure progress over time toward meeting goals.

• Assure known risk factors are addressed.

• Demonstrate compliance with HCBS requirements.
The priorities, strengths, support needs and risk factors identified in the PCSP must be addressed and accounted for in the service implementation plan for those areas in which the organization is paid to provide services. The more comprehensive the nature of paid services being provided, the more detailed and accountable the service implementation plan should be.
Once you receive a PCSP, sign and return it to acknowledge you are ready to begin services. Use the PCSP to develop an implementation plan which documents your plan for service delivery and aligns with the person’s PCSP.

The service implementation plan:
- Plans for community integration.
- Identifies natural supports.
- Details the plans for achieving goals.

Direct support professionals complete training specific to the PCSP, the person being supported and his or her implementation plan.
The service implementation plan:

<table>
<thead>
<tr>
<th>Reflects the <strong>priority outcomes/requirements</strong> identified in the PCSP.</th>
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<tbody>
<tr>
<td>Describes how supports and services assist the individual to <strong>engage in community life</strong> and maintain <strong>control over personal resources</strong>.</td>
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<tr>
<td>Provides opportunities to <strong>seek employment</strong> and work in <strong>competitive integrated employment</strong>, if desired.</td>
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<tr>
<td>Includes <strong>functional goals/training areas</strong> and methods to measure progress.</td>
</tr>
<tr>
<td>Demonstrates services and supports are <strong>linked to individual strengths, preferences</strong>, and assessed clinical <strong>and support needs</strong>.</td>
</tr>
<tr>
<td>Describes individualized <strong>back-up plans</strong> and strategies for service delivery.</td>
</tr>
<tr>
<td><strong>Identifies risks</strong> included in the PCSP and any others subsequently identified, strategies that will be used to <strong>mitigate risk</strong>, and who is responsible for implementing these strategies.</td>
</tr>
</tbody>
</table>
The service implementation plan:

| Identifies **all services and supports** to be provided **regardless of provider of funding source**, including **type, methods, frequency, duration** and **staff assigned** as applicable. |
| Includes **justification for any restriction(s)** or modifications that limit the person’s choice, access or otherwise conflict with HCBS standards. |
| Includes basic **descriptive, diagnostic, demographic and medical information**. |
| Reflects ongoing review, monitoring and updating if necessary by the provider agency. |
| Is **updated** to reflect changes in the PCSP **at least annually** and more often if warranted by circumstances, a change in functional status or at the request of the individual. |
Quality

Reportable events management and quality monitoring
Quality is not only one of our values but a primary responsibility of our providers. Providers should review both member and provider responsibilities, which are detailed in the provider manual.
Mandatory child abuse reporting:

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

*Older adults and those adults with disabilities want to live independently. They need to be safe and as independent as possible. Many cannot depend upon or trust those nearest to them. Those they love the most may abuse them. Only 1 in 23 cases are reported. It is not only your moral and ethical obligation to report elder abuse but also your legal obligation.*

- Excerpt from the Tennessee Department of Human Services
Managed care organizations (MCOs) work in collaboration with the Department of Intellectual and Developmental Disabilities (DIDD) to manage the ECF CHOICES reportable events management system.

The reportable events management system provides reports to DIDD and the MCOs.

Providers are responsible for tracking/trending reportable and nonreportable events.

**Tools and grids:**

- *ECF CHOICES Reportable Events Guidance Chart*
- *ECF CHOICES Reportable Events and Provider Investigations Refresher*
- *ECF CHOICES Reportable Event Form*
Reportable events management (cont.)

- Tier 1 reportable events are investigated by DIDD with review by the MCO for potential quality of care issues.
- Tier 2 reportable events are investigated by ECF CHOICES providers with review by the MCO (additional investigation as needed).
- Tier 3 reportable events do not require an investigation; provider is responsible for follow up, with review by MCO.
- Nonreportable events do not require an investigation; provider is responsible for appropriate action, including documentation, with review as part of DIDD and/or the MCO quality assurance process.
Quality monitoring focuses on the quality of services that go above and beyond the minimum compliance standards.

Compliance with licensure and contracting requirements are monitored separately by the MCO and the relevant licensing authority.

Certain ECF CHOICES services are monitored by DIDD through a contract arrangement (Interagency Agreement) between TennCare and DIDD.

The ECF CHOICES Quality Monitoring Surveys are focused on recognizing quality that is not required, but is a sign of a provider choosing to exceed compliance expectations.

Results of these surveys are forwarded to the applicable MCO to be integrated into their quality system.
Quality monitoring — by DIDD

- Employment services:
  - Exploration
  - Discovery
  - Situational observation and assessment
  - Job development plan or self-employment plan
  - Job development or self-employment start-up
  - Job coaching; integrated, competitive employment
  - Job coaching; self-employment
  - Coworker supports
  - Career advancement
  - Supported employment — small group supports
  - Integrated employment path services
• Community integration support services
• Independent living skills training
• Personal assistance
• Respite (this service is monitored in conjunction with personal assistance and supportive home care)
• Supportive home care (essential family supports group only)
• Community transportation (agency-provided only)
• Community living supports, and community living supports — family model
DIDD will conduct the Consultative Survey within the first year of notification of provision of services to at least one member.

The Consultative Survey Performance Level Rating will be determined as follows:

- Best: 76 or higher
- Better than Good: 51-75
- Good: 26-50
- OK: 1-25

All ratings represent performance above compliance.

Upon completion of the consultative survey, providers will be placed on the Annual Quality Monitoring Survey Schedule.
Quality monitoring tools

Tools:

*Employment and Community First CHOICES Quality Monitoring Consultative Survey Process Overview*

*Employment and Community First CHOICES Quality Monitoring Consultative Survey Tool*
Compliance and credentialing
According to Section 6032 of the DRA of 2005, DRA compliance includes educating employees, contractors and agents on the following topics:

- *Federal False Claims Act* and administrative remedies for false claims and statements
- Any civil or criminal penalties under state false claims laws
- Whistleblower protections under federal and state law

**Deficit Reduction Act (DRA) compliance**
The **DRA** also sets forth the following compliance standards:

- **Background/exclusion checks review:** Reviews should be conducted to verify that background checks are completed prior to an employee providing services to members, and exclusion checks are completed on a monthly basis.

- **HCBS provider review:** An audit should be conducted to assess compliance of the provider’s policies and procedures related to the ECF CHOICES program, employee records and training.
The National Committee for Quality Assurance (NCQA) develops quality standards and performance measures. These measures and standards are used for credentialing/recredentialing.

Completed, clean applications to join the Amerigroup network are processed within 30 days.

Participation applications can be requested at https://providers.amerigroup.com/Pages/tennessee-apprequest.aspx
Recredentialing occurs every three years or sooner if required by state law

Ongoing CHOICES and ECF CHOICES HCBS providers must be recredentialed at least annually

Promptly notify Amerigroup by letter if your licensure, TIN, demographics or participation status changes
Provider demographic updates

- Provider demographic information can be updated through local Provider Relations representatives.
- Operating office location additions or changes require a streamlined application to be credentialed.
- For name changes, include updated W-9 form.
- *Disclosure for Provider Entity* and *Provider Person* forms must be registered at the Division of TennCare.
  - The Bureau of TennCare is now collecting *Disclosure of Ownership* information for new and existing providers, both provider persons and provider entities. Whether or not you are a new provider to TennCare or an existing Medicaid provider, you will need to register your information on the TennCare Provider Registration site at [https://www.tn.gov/tenncare/providers/provider-registration.html](https://www.tn.gov/tenncare/providers/provider-registration.html).
All participating provider organizations considering a CHOW must notify the MCO(s) at least 60 days prior to the anticipated effective date of change utilizing the universal Provider Change of Ownership Notification Form.

**What is a CHOW?**

A CHOW typically occurs when there is a change in the entity ownership. This can include a change in individuals, corporations or general partnerships (e.g., a new partnership agreement would constitute a CHOW).

**Who should submit the Provider Change of Ownership Notification Form?**

The current legal entity (seller) should submit all changes on the universal Provider Change of Ownership Notification Form, and the new legal entity (buyer) should complete the applicable credentialing application form(s).
How do I complete a CHOW notification?

Participating providers must complete the *Provider Change of Ownership Notification Form* and submit it with all required documents to the appropriate MCO(s) to initiate the CHOW process. A copy of the universal *Provider Change of Ownership Notification Form* can be found on each MCO’s provider website.

Where do I send my completed CHOW notification?

Please submit a completed request and supporting documents for CHOW to tnltsprovidercontracting@anthem.com.
For provider terminations, please refer to the termination clause in your contract. The following documentation is required for termination notices:

- Request on provider letterhead
- EIN/TIN
- Name of provider(s)
- Effective date of termination
- Signature of authorized representative
Site visits

Types:

• Initial — Occurs prior to contracting or when adding an additional program
• Orientation and training — Occurs within 30 days of contract date
• Recredentialing — Annual visit that will involve a full audit

Provider preparation:

• Review and complete the documents sent by Provider Relations prior to the site visit
• Arrange for key people within the agency to attend
• Ensure policies and procedures are ready and available
• Ensure employee records are available and background check roster is complete and up-to-date
• Prepare properly to limit how long it takes to conduct the visit
ECF CHOICES providers are obligated to:

- Conduct criminal background checks for all associates or a background check from a licensed private investigation company.
- Maintain documentation verifying the person’s name does not appear on the state abuse registry or the state and national sexual offender registry.
- Screen their employees and contractors initially, and on an ongoing monthly basis, to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP or any federal health care programs and not employ or contract with an individual or entity that has been excluded or debarred.
Effective July 1, 2017, all contracted ECF CHOICES and CHOICES providers began tracking the following information utilizing the provider background check roster template for employees and volunteers as listed below:

• Employee or volunteer name
• Employee or volunteer SSN
• Title
• Hire date (or start date, if a volunteer)
• First date providing services to members
• Criminal background check (for employees and volunteers with direct contact only)
  • Tennessee Abuse Registry check date
  • National Sex Offender Registry check date
  • Tennessee Sexual Offender Registry check date
• List of Excluded Individuals/Entities (LEIE) check date
• Whether the employee or volunteer's record was audited, if applicable, by one of the MCOs during their credentialing visit, and if so, the date of the audit and the name of the MCO that completed the audit
Employees and volunteers who will have direct contact with members must have a criminal background check, including registry checks, which includes verification that the employee or volunteer's name does not appear on any of the following registries: the Tennessee Abuse Registry, the national and Tennessee sex offender registries, or the LEIE.

For all volunteers and employees who qualify to provide services constituting only incidental contact with members, the provider shall maintain proof that requisite registry checks were completed.
Claims and payments
Claims can be submitted via HealthStar, Availity or clearinghouse

**HealthStar:**
- HealthStar EVV is a web-based platform that uses GPS technology to record the time and location of a member’s caregiver at check-in and check-out of an appointment
- You can submit claims directly from HealthStar
- You are also able to view the status of exported claims

**Availity Portal:**
- The Availity Portal offers secure access to manage daily transactions with payers
- You don’t need any special software to get started with Availity
- With Availity, you can verify eligibility, submit claims and check the status of claims
The HealthStar EVV system is a web-based system

The provider login will be provided to you as part of your HealthStar welcome packet

You will designate an administrator who will be allowed to set up your employees with user names and passwords

Authorizations are sent to providers via HealthStar

Members’ PCSPs are also communicated via HealthStar

There are many helpful reports available to providers in HealthStar
To get started with Availity, you will need the following information:

• Basic information about your organization, including your federal TIN
• The name of someone with legal authority to sign agreements for your organization
• The name of a primary access administrator to oversee implementation and maintain access for your entire organization
Clearinghouse and electronic claims payer contact numbers:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Payer ID</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td>26375</td>
<td>1-800-282-4548</td>
</tr>
<tr>
<td>Emdeon</td>
<td>27514</td>
<td>1-866-858-8938</td>
</tr>
<tr>
<td>Smart Data Solutions</td>
<td>81237</td>
<td>1-855-650-6590</td>
</tr>
</tbody>
</table>

For assistance with electronic claims transmissions to Amerigroup, call the Electronic Data Interchange (EDI) hotline at 1-800-590-5745.
For claim inquiries, call Provider Services at 1-800-454-3730, and follow the prompts to speak to a specially trained customer service agent.

Timely filing is 120 calendar days from the date of service.

Corrected claims via UB-04, CMS-1450 or CMS-1500 (08-05) forms must be submitted within 120 days from the date of service for outpatient services (except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility).
What is the difference between a rejected and a denied claim?

Rejected:
A rejected claim does not enter the adjudication system due to missing or incorrect information.

Denied:
A denied claim goes through the adjudication process but is denied for payment.
There are separate and distinct appeals processes for members and providers depending on the services denied or terminated.

- **Provider appeals:**
  - Refer to your provider manual and/or the denial letter for the correct appeals process.
  - To submit a payment dispute, please complete the *Provider Payment Dispute Form* located online at [https://providers.amerigroup.com/TN](https://providers.amerigroup.com/TN) and submit per instructions.

- **Member appeals:**
  - Members have the right to file a medical appeal regarding an adverse action taken by Amerigroup.
  - Refer to your provider manual and/or the denial letter for the correct appeals process.
Electronic payment services

If you sign up for electronic remittance advice (ERA)/electronic funds transfer (EFT), you can:

• Start receiving ERAs and import information directly into your patient management or patient accounting system.
• Route EFTs to the bank account of your choice.
• Create custom reports within your office.
• Access reports 24 hours a day, 7 days a week.

To register for ERA/EFT, contact PaySpan at:

• 1-877-331-7154
• https://www.payspanhealth.com
Your support system

- Provider Relations representatives
- Support coordination
- EDI
- Provider manual
- Amerigroup provider website
- TennCare website
Contacts

Provider Services
1-800-454-3730

Dedicated Service Unit (DSU)
1-866-840-4991

HealthStar
1-855-329-2116
customerservice@hlthstar.com

LTC authorization email
ltcprovreq@amerigroup.com

Amerigroup internal EVV team
TN1ltcevvcs@amerigroup.com

Availity
1-800-282-4548

Amerigroup contracting email
tnltsprovidercontracting@anthem.com
Reference tools and provider website

- Provider manual
- ECF CHOICES Provider Manual Supplement
- ECF CHOICES Provider Quick Reference
- Amerigroup provider website

Our provider website, https://providers.amerigroup.com/TN, offers you a full complement of online tools including:

- Enhanced account management tools
- Detailed eligibility lookup tool with downloadable panel listing
- More comprehensive downloadable member listing tool
- Submission tool for easier authorization
- New provider data, termination and roster tools
Quick reference information

For member eligibility, claims information and general inquiries, call Provider Services at 1-800-454-3730.

**Additional contact information:**

- Provider Services fax: 1-800-964-3627
- EDI hotline: 1-800-590-5745
- Dedicated Service Unit: 1-866-840-4991
- Availity: 1-800-AVAILITY (1-800-282-4548)
- EVV help desk: 1-855-329-2116
- Family Assistance Service Center: 615-743-2000
- Fraud and Abuse Hotline: 1-800-433-3982
Thank you for teaming up with Amerigroup