

CHAPTER 6

GENERAL PROVIDER REQUIREMENTS

6.1. Introduction

This chapter provides information about requirements that are applicable to providers rendering services within the Division of Mental Retardation Services (DMRS) service delivery system. Provider records and training are covered in individual chapters that follow, as the volume of information to be covered is more extensive than that related to the topics covered in this chapter.

6.2. Licensure Requirements

Chapter 5 indicates that all providers who require licensure must obtain the appropriate license prior to establishing a provider agreement with DMRS. Required licensure for different provider types is listed in *Table 5.5*. It is required that providers maintain licensure for services offered at all times while services are being rendered within the DMRS system. Providers who have allowed licensure to lapse will not be reimbursed for services provided during the lapsed period. Providers will be required to show proof of current licensure during DMRS annual quality assurance surveys and during TennCare Quality Assurance surveys. Proof of licensure may be required during other external reviews or surveys, such as those conducted by the Centers for Medicare and Medicaid Services (CMS), the Tennessee Office of the Comptroller or the Tennessee Department of Health.

6.3. Personnel Requirements

6.3.a. Required Personnel Policies: Personnel policies are required if staff are employed by a provider. Personnel policies are not required of independent providers or when services are provided only by contracted staff in accordance with a DMRS approved subcontract. The following basic personnel policies are otherwise required to be submitted to DMRS before a provider receives initial approval to enter into a provider agreement. Basic personnel policies must be updated, maintained and implemented while a DMRS provider agreement remains in effect. Required personnel policies must address:

- 1) Procedures for hiring staff, including minimum staff qualifications for each staff position;

- 2) Development and communication of job descriptions for each staff position;
- 3) Procedures for initiating and resolving employee complaints;
- 4) Requirements pertaining to utilization of employee-owned vehicles to transport service recipients, if applicable;
- 5) Procedures for initiating/employing progressive employee disciplinary actions, including, but not limited to, those related to Title VI non-compliance, drug-free workplace violations, and substantiation of staff abuse/neglect/exploitation of service recipients;
- 6) Procedures for staff termination, suspension and placement on the Department of Health's Tennessee Abuse Registry;
- 7) Procedures for tuberculosis testing in accordance with current Department of Health policy (see current Policy in *Appendix I*).
- 8) Procedures pertaining to drug-free workplace requirements.

6.3.b. Staff Requirements: The approved waiver documents list general requirements that are applicable to all provider-employed staff, subcontractors and their staff or independent providers. DMRS utilizes the same requirements for providers and staff and subcontractors rendering state-funded services. The general requirements are:

- 1) Staff must be at least eighteen (18) years of age;
- 2) Staff who have direct contact with or direct responsibility for service recipients must be able to effectively read, write and communicate verbally in English and must be able to read and understand instructions, perform record-keeping and write reports;
- 3) Staff responsible for transporting a service recipient must have a valid driver's license and automobile liability insurance of the appropriate type;
- 4) Staff who have direct contact with or direct responsibility for service recipients shall pass a criminal background check performed in accordance with Title 33; and
- 5) Staff who have direct contact with or direct responsibility for service recipients must not be listed on the Tennessee Abuse Registry, the Tennessee Sexual Offender Registry, or the Tennessee Felony Offender List.

6.3.c. Title 33 Requirements for Background Checks: In accordance with Title 33 (T.C.A. 33-2-1202), each provider must have a process for ensuring that statewide criminal background checks are performed for each employee, volunteer or subcontractor employee having direct contact with or direct responsibility for service recipients. The employee/job applicant or volunteer must be told that a criminal background check will be conducted. Prior to assignment or change of responsibilities involving direct contact with or direct responsibility for service recipients, certain information must be obtained from the employee/job applicant or volunteer and required information must be submitted

to the entity conducting the criminal background check. Information to be obtained from the employee includes:

- 1) A work history inclusive of a continuous description of activities during the past five (5) years;
- 2) At least three (3) personal references, with one of the references having known the employee for at least five (5) years;
- 3) A release of investigative records to the provider for the purpose of verifying the accuracy of criminal violation information stated on the employment application; and
- 4) Either fingerprint samples for a criminal history background check conducted by the Tennessee Bureau of Investigation (TBI) or Federal Bureau of Investigation (FBI) or information for a criminal background investigation conducted by a Tennessee-licensed private investigation company.

The TBI is now offering The Tennessee Applicant Processing Services System through Sylvan/Identix Fingerprint Systems. Interested providers should contact the TBI for additional information about this option. A current list of licensed private investigation companies in Tennessee can be accessed via the internet. Please see *Appendix F* for the current website address.

6.3.d. Additional DMRS Requirements Pertaining to Background Checks: In addition to Title 33 requirements for criminal background checks, DMRS requires the following pertaining to job applicants/employees and volunteers:

- 1) For any employee that has lived in Tennessee for one (1) year or less, a nationwide background check is required; and
- 2) Employees must be directly supervised and not left alone with service recipients until such time as background check results are available to the provider.

6.3.e. Reimbursement for Criminal Background Checks: Reimbursement for criminal background checks will be made as follows:

- 1) The provider requesting that a background check be conducted will pay the TBI, the FBI or the Tennessee licensed private investigation company. The TBI and FBI will be paid in accordance with the amounts established by T.C.A. § 38-6-103.
- 2) DMRS will provide reimbursement of criminal background checks only when:
 - The provider has a current, signed *DMRS Provider Agreement* and is licensed by the Department of Mental Health and Developmental Disabilities;

- Background checks are done for employees whose responsibilities include direct contact with or direct responsibility for DMRS service recipients;
- Background checks are completed by the TBI, FBI or a Tennessee licensed private investigation company;
- The employee is hired by the provider to provide services funded by DMRS; and
- Funding is available for DMRS to provide payment up to the published maximums.

6.3.f. Title 33 Requirements for Employee Reference Checks: Work and personal references must be checked prior to employment of a job applicant. Requirements for reference checks are as follows:

- 1) At a minimum, the provider must directly communicate with the most recent employer and any employer who employed the job applicant for more than six (6) months within the past five (5) years; and
- 2) At a minimum, the provider must directly communicate with at least two (2) of the personal references provided by the job applicant.

6.3.g. Requirements Pertaining to the Continued Employment of Provider Staff: Requirements include:

- 1) The provider must employ a process for periodically evaluating the performance of staff; and
- 2) The provider must implement a written policy that ensures that employees do not continue to provide direct services or have direct responsibility for service recipients when the employee is convicted of criminal activity during employment (e.g., fraud, misappropriation of funds, breach of fiduciary duty) or if an employee is placed on the Department of Health's Tennessee Abuse Registry;

6.4. Provider Conflict Resolution Procedures

Title 33 (TCA 33-2-602) requires that all providers licensed by the Department of Mental Health and Developmental Disabilities (DMHDD) develop and implement clear, written conflict resolution procedures. DMRS requires that conflict resolution procedures be developed for all providers who execute a DMRS provider agreement. Conflict resolution procedures are intended to address disputes that service recipients, families or legal representatives may have with the provider. Conflict resolution policies and procedures must be communicated to service recipients, family members, legal representatives, advocates, support coordinators/case managers and others who may initiate conflict resolution on behalf of the service recipient. Providers may not cease to provide services

while conflict resolution is pending unless the service recipient agrees to select a new provider. Conflict resolution policies are to include:

- 1) A means to resolve conflict informally;
- 2) A description of the review process initiated when a conflict is identified or a complaint is presented;
- 3) Identification of staff responsible for decision making at each level of conflict resolution;
- 4) The time frames involved in each level of conflict resolution; and
- 5) The rights and responsibilities of the parties involved in the conflict resolution procedure.

6.5. Required Provider Policies

In addition to the basic personnel policies listed in *Section 6.3.a.*, certain other policies are required before approval can be granted for a DMRS provider agreement to be executed. These policies must be updated, maintained and implemented while a provider agreement with DMRS is in effect. Required policies must address:

- 1) Showing respect to service recipients during service delivery;
- 2) Protecting service recipients' rights;
- 3) Using positive approaches with service recipients (required only if staff are responsible for direct support and supervision of one or more service recipients);
- 4) Obtaining emergency and/or urgent health care for service recipients (required only if staff are responsible for direct support and supervision of one or more service recipients);
- 5) Addressing health care needs specified in the individual transition plan (ITP) or individual support plan (ISP) (required only if staff are responsible for direct support and supervision of one or more service recipients);
- 6) Serving as an advocate for the service recipient and referring to external advocacy services as needed;
- 7) Taking appropriate action in emergency situations;
- 8) Maintaining a sanitary and safe environment, including fire safety precautions in provider offices, individual homes and other sites where services are delivered (required only if the service provider is responsible for maintaining a service delivery site or an office space visited by service recipients);
- 9) Managing and accounting for service recipient personal funds (required only if a provider manages service recipient funds);
- 10) Maintaining a well-trained workforce;
- 11) Managing and reporting incidents (see *Chapter 18*);
- 12) Maintaining Title VI compliance (see *Chapter 2, Section 2.7.*); and

- 13) Maintaining and monitoring service recipients records, including compliance with confidentiality requirements and the Health Insurance Portability and Accountability Act (HIPAA) standards (see *Chapter 8*), supervisory reviews of records and organization/storage locations for record components (supervisory reviews of records are required only for providers responsible for maintaining the comprehensive and/or residential record).

6.6. The Provider Management Plan

Providers of residential services, day services and/or personal assistance services are required to complete and follow a management plan. The management plan is a formal, written plan that describes how the provider conducts business to ensure successful operation and compliance with applicable program requirements. The plan describes how the provider implements policies and procedures to assure the health, safety and welfare of service recipients.

6.6.a. Required Components of a Management Plan: The required components of a Management Plan may differ depending upon the type of services provided. Basic components of the Management Plan include:

- 1) The provider's mission statement and philosophy of service delivery;
- 2) An organizational chart if two (2) or more service recipients are provided services;
- 3) A description of service(s) offered by the provider;
- 4) Demographic information about the provider's service recipient population;
- 5) Any criteria employed by the provider in determining whether services to a service recipient will be refused or terminated due to inability to ensure safe provision of services;
- 6) A list of any fees charged, categorized by service;
- 7) A staffing plan for each location (see *Chapter 9, Section 9.8.* for staffing plan requirements for residential providers and *Chapter 10, Section 10.4.d.* for staffing plan requirements for day service providers);
- 8) The geographic location where services are available;
- 9) A description of the Board of Directors or Local Advisory Group, including the composition of the board/advisory group, the names and occupations of board/advisory group members, the number of representatives from each geographic area served, the length of board/advisory group terms and the number of consumers/family member representatives;
- 10) Complaint resolution (grievance) procedures for service recipients and legal representatives/family members;

- 11) A description of how service recipients' health care needs will be managed (see *Chapter 11*);
- 12) A description of the provider's process for self-assessment to determine strengths and weakness in delivery of services (see *Section 6.6.b.*);
- 13) A description of the provider's internal quality assurance/quality improvement plan (see *Section 6.6.c.*); and
- 14) Policies and procedures targeted toward ensuring prevention of harm to service recipients (i.e. Prevention Plans in accordance with *Chapter 18, Section 18.2*).

6.6.b. Management Plan Components Applicable Only to Certain Provider Types:
Additional Components of a Management Plan required for certain providers include:

- 1) For providers of transportation services or providers of services that include transportation as a component of the service, a description of the provider's transportation system, including service recipient access to transportation (e.g., a description of how service recipients will be provided adequate access to transportation for medical appointments and other activities that may specified in the ISP);
- 2) For providers, including providers of paid conservatorship services, who assist in personal funds management or who manage funds on behalf of a service recipient(s), a description of how personal funds management policies are implemented to account for and prevent misuse of service recipient's personal funds (see *Section 6.10.*);
- 3) For support coordination providers and other providers who employ staff who are responsible for supervision of a service recipient, a Supervision Plan (see *Section 6.6.e.*);
- 4) For providers who utilize unlicensed direct support staff to administer medications, a medication administration policy approved by DMRS.

6.6.c. Provider Self-Assessment: A provider's self-assessment process ensures that an internal mechanism exists for ongoing review of the effectiveness of services provided. Self-assessment allows a provider to identify systemic issues and initiate corrective actions before such issues are discovered by the state and federal agencies responsible for monitoring service provision. Each provider is responsible for completion of self-assessment activities identified in the management plan and for evaluation/revision of self-assessment processes. The following components must be included in self-assessment activities completed throughout the year between DMRS annual QA surveys:

- 1) Monthly reviews to determine staff performance in assisting service recipients to complete action steps and/or progress toward outcomes;
- 2) Review of processes for updating service recipient records in a timely manner;

- 3) Review of trends related to service recipient and family satisfaction with services provided;
- 4) Review of incident trends, including those related to medication errors and other health and safety factors;
- 5) Review of external monitoring reports for the previous twelve (12) month period;
- 6) Review of any sanctions imposed during the previous twelve (12) month period;
- 7) Review of personnel practices, including staff recruitment and hiring, staff training, and staff retention/turnover;
- 8) Review of processes intended to ensure timely access to health-related interventions, such as health care appointments and follow-up activities;
- 9) Review of trends related to high risk reviews;
- 10) Review of current policies and management plan(s), including success in implementing policies/plans and the degree to which policies/plans ensured compliance with program requirements;
- 11) Application of the current DMRS Quality Assurance Survey Tool to a sample of service recipients; and
- 12) Evaluation of the effectiveness of the management plan and modification as needed to achieve quality assurance and compliance outcomes.

6.6.d. Provider Internal Quality Assurance/Quality Improvement Plans: The quality assurance/quality improvement (QA/QI) plan is the mechanism for addressing the issues identified during the self-assessment process. The QA/QI plan is to be focused on resolution of systemic issues at the provider level. Systemic issues are those that affect or have the potential to affect a number of service recipients. The QA/QI plan specifies how any necessary systemic improvements will be made through a process which includes:

- 1) Analysis of the cause of any serious issues/problems identified (serious issues/problems are those that impact multiple service recipients or those that have health and safety consequences requiring medical treatment of one or more service recipients);
- 2) Development of observable/measurable quality outcomes related to resolving the causal factors;
- 3) Establishment of reasonable timeframes for implementation of quality initiatives;
- 4) Assignment of staff responsible for completion of actions and achievement of quality outcomes; and
- 5) Modification of policies, procedures and/or the management plan (potentially including the QA/QI plan) to prevent recurrence of issues/problems that were resolved.

All provider staff should have access to the QA/QI plan and have a basic knowledge of what is included in the plan to ensure that implementation occurs from the direct service level all the way up to and including top management.

6.6.e. Evaluation of Provider Self-Assessment Activities and QA/QI Plans: DMRS will evaluate provider self-assessment processes and QA/QI plans based on:

- 1) Whether the required components of the self-assessment process were completed within the timeframe between annual QA surveys;
- 2) Whether self-assessment activities result in timely identification and correction of issues/problems;
- 3) Whether the QA/QI plan is clearly related to the issues and causal factors identified during self-assessment;
- 4) Whether the QA/QI plan is revised to address identified issues/problems in a timely manner;
- 5) Whether there is evidence that staff at all levels of the provider organization have access to and knowledge of the components of the QA/QI plan;
- 6) Whether staff are held responsible for completing assigned self-assessment and QA/QI activities and duties; and
- 7) Whether the results of the self-assessment activities and the QA/QI plan are made available in an understandable format to staff, service recipients, family members, the provider governing body and to other interested parties who request the information.

6.6.f. Supervision Plans: A supervision plan is required when a provider employs staff who are responsible for direct supervision of service recipients. Supervision plans address how the provider accomplishes major supervisory functions, including:

- 1) Ensuring that staff understand their job duties and performance expectations;
- 2) Ensuring that staff acquire the knowledge and skills needed to complete job duties and meet performance expectations;
- 3) Monitoring staff performance to ensure that performance issues are promptly identified and rectified by requiring or providing additional training, increased supervision, counseling, and/or appropriate disciplinary action;
- 4) Ensuring that a minimum of three (3) unannounced supervisory visits are conducted at each service site during each calendar month, including visits that monitor staff performance during sleep hours, on weekends and on holidays;
- 5) Developing and implementing policies that effectively control the incidence of employees having visitors, including family members, in a service recipient's home that are not present based on the wishes of the service recipient(s);

- 6) Developing and implementing policies that prevent employees from conducting personal business, such as running errands or attending to their children or other family members while on duty; and
- 7) Developing and implementing policies that ensure that service recipients' homes are safe, clean and appropriately furnished.

Providers are required to evaluate the effectiveness of the supervision plan and revise as necessary.

6.7. Provider Governance

Not-for-profit providers are required to be governed by a board of directors. For-profit providers are required to have a local advisory group that provides input regarding the policies and procedures employed to direct the provision of services.

6.7.a. Requirements for Not-For-Profit Provider Boards of Directors: An appointed board of directors is expected to follow all applicable state and federal laws pertaining to not-for-profit corporations (Title 48 Chapters 51-68, accessible via a link on the DRMS website version of the manual).

- 1) If the Board of Directors is made up of out of state members, a local advisory group must be established that is comprised of Tennessee residents;
- 2) Minutes to all Board meetings will be recorded, inclusive of names of those present and description of all actions taken at the meeting;
- 3) Board meetings will be held at least quarterly and more frequently if needed to effectively discharge Board duties;
- 4) A quorum of Board members must be present for Board business to be conducted during a Board meeting;
- 5) Board members will be required to sign confidentiality agreements and the provider will be responsible for maintaining HIPAA compliance in presentation of information to board members;
- 6) Board members will be regularly provided with current information pertaining to:
 - Provider fiscal status;
 - Development and revision of operational policies, procedures and plans;
 - Results of internal self-assessment activities; and
 - Reports of compliance reviews conducted by external monitoring entities;
- 7) The board will be composed of individuals representing different community interest groups, including persons with disabilities and/or family members of people with disabilities;

- 8) Board minutes will reflect presentation of service recipient/family input and consideration of the information presented in revising provider operational policies, procedures and plans as appropriate;
- 9) New Board members will attend an orientation within ninety (90) calendar days of appointment for the purpose of receiving information pertaining to:
 - The duties and responsibilities of Board members;
 - An introduction to the provider agency, including services provided and an overview of the provider's mission, purpose, and operational goals/objectives;
- 10) All Board chairs will attend DMRS new provider orientation or view a DMRS orientation videotape presentation within ninety (90) calendar days of assuming office;
- 11) Policies will be developed and implemented to address conflict of interest between board members and the provider;
- 12) Board minutes will reflect that Board members are provided with a copy of the Title 48 requirements pertaining to conflict of interest or a copy of provider policies that reflect Title 48 conflict of interest requirements;
- 13) The Board will review, recommend revisions and approve the provider's charter, bylaws, purpose, mission statement, goals/objectives and operational policies/procedures as needed;
- 14) The Board will review and take action to resolve in a timely manner any fiscal issues identified in provider financial statements (financial statements must be reviewed by the Board at least quarterly);
- 15) The Board will review and take action to resolve any issues identified through provider self-assessment or through external compliance/quality monitoring at least annually or more frequently if needed to ensure continued operation of the provider; and
- 16) The Board will appoint a chief executive officer to whom the Board will delegate the responsibility and authority to implement Board-approved policies/procedures/plans, direct provider day-to-day operations (e.g. personnel management and authorization of expenditures) and conduct annual self-assessment of provider performance.

6.7.b. Requirements for For-Profit Provider Local Advisory Groups: For-profit providers of residential, day, personal assistance and support coordination services must have a local advisory group. Requirements include:

- 1) Minutes to all advisory group meetings will be recorded, inclusive of the names of those present and a description of issues discussed and recommendations made;
- 2) Advisory group meetings will be held at least quarterly and more frequently if determined necessary to complete duties;

- 3) The advisory group will be composed of individuals representing different community interest groups, including persons with disabilities and/or family members of people with disabilities;
- 4) Provider policies will support persons with disabilities and/or family members in attending advisory group meetings;
- 5) Advisory group members will be required to sign confidentiality agreements and the provider will be responsible for maintaining HIPAA compliance in presentation of information to advisory group members;
- 6) Providers will develop mechanisms for presenting input from service recipients and family members to advisory group members;
- 7) Advisory group meeting minutes will reflect presentation of service recipient/family input and consideration of the information presented in revising provider operational policies, procedures and plans as appropriate;
- 8) Advisory members are encouraged to attend orientation that includes an overview of provider operations and a description of the duties and responsibilities of advisory group members;
- 9) Advisory group members will be advised of the need to revise operational policies, procedures and plans and asked to provide input regarding changes; and
- 10) Providers will provide response to advisory group recommendations by incorporating recommendations into operational policies, procedures or plans or by documenting the reasons that recommendations were not acted upon.

6.8. Assuring Staff Sufficient to Provide Services and Adhering to Service Schedules

Any provider who agrees to provide a direct service such as residential services, day services, personal assistance services, nursing services or therapy services must ensure that sufficient qualified and trained staff are available to provide the service in accordance with the staffing schedule or appointment time arranged. This applies to independent providers of service as well as providers who employ a number of staff for service provision. Provisions must be made for coverage of services and supervision of staff as required when independent providers or employees take periods of extended leave, when staff resign from employment or when staff are sick or are otherwise unable to come to work due to unexpected events or circumstances. The service recipient's support coordinator or case manager and caregiver (as applicable) must be notified with as much advance notice as possible any time that a provider anticipates that expected/scheduled direct support staff services, such as personal assistance, may not be available.

It is anticipated that provider and service recipient schedules may unexpectedly change for a number of reasons. Common courtesy should be observed in notifying the appropriate parties of such changes to avoid the frustration and cost associated with

missed appointments. For instance, clinical and other service providers must ensure that provider direct support staff and/or family caregivers at the service recipient's home or day service site are notified if services are to be rescheduled for a different time or date. Conversely, the service recipient's direct support staff provider and/or family caregivers are expected to notify clinical and other service providers if an appointment needs to be rescheduled due to a change in the service recipient's schedule. Notifications related to changes in provider or service recipient schedules should occur as soon as possible after the need to reschedule has been identified.

6.9. Provider Subcontracts

Providers with an executed DMRS provider agreement must develop written subcontracts when any part or requirement of a service as defined by the service definition and provider agreement is rendered by individuals who are not directly employed (either as paid or volunteer staff) by the provider. DMRS providers must hold any subcontractor(s) to the same terms and conditions specified in the DMRS Provider Agreement. Providers relying upon subcontracted entities for the provision of services are fully responsible for any services provided by or with the assistance of the subcontractor. Provider subcontracts are to be submitted to DMRS Central Office for approval. Provider subcontracts are also subject to TennCare approval. A subcontract is provided in *Appendix D*. DMRS is currently finalizing a standard subcontract format which, once approved by TennCare, will be required to be used by DMRS providers when subcontracts are established.

6.10. Provider Responsibilities Pertaining to Personal Funds Management

6.10.a. Personal Allowance Funds: A service recipient's personal allowance is that portion of personal funds that is reserved for the service recipient's use for the purchase of personal items and that may not be applied to the cost of services. Personal allowance funds belong to the service recipient and are kept in the service recipient's home. Personal allowance funds may be used to purchase clothing, grooming supplies, entertainment equipment, leisure activities refreshments during community activities or other personal items desired by the enrollee. DMRS provider requirements related to personal allowances include:

- 1) Providers will ensure that service recipients have access to personal funds at all times unless limitations to access are specified in the ISP;
- 2) Providers will encourage use of personal allowance funds to purchase personal items needed or desired by the service recipient;
- 3) Providers will ensure that personal allowance funds will not be allowed to accumulate in the service recipient's home in excess of \$100;

- 4) Providers will assist in establishing checking or savings accounts for deposit of funds as requested by the service recipient in the service recipient's name in a bank chosen by the service recipient;
- 5) Providers will monitor for and advise the service recipient or entity that assists with management of personal funds of accumulations of personal allowance funds that could result in loss of benefits (e.g., Medicaid or Social Security);
- 6) Providers will ensure that personal allowance funds transactions are posted no later than midday on the day following the date of the transaction; and
- 7) Providers will ensure that personal allowance records are reconciled on a monthly basis.

6.10.b. Responsibilities Related to the Support of Service Recipients in Managing Personal Funds: In accordance with TennCare policy, which specifies provider requirements related to personal funds management, provider responsibilities include:

- 1) Supporting service recipients who are capable of managing personal funds to the extent necessary;
- 2) Providing appropriate personal funds management training in accordance with the ISP for service recipients who desire greater involvement in management of personal funds but have skills deficits;
- 3) Assisting service recipients who are unable to manage personal funds to select another person to act on their behalf (e.g., enrollees receiving Social Security may complete forms to designate a "Representative Payee"); and
- 4) Assisting legal representatives of service recipients in making an informed decision regarding whether to manage the service recipient's personal funds or select a person or entity to act in the service recipient's behalf.

6.10.c. Provider Responsibilities Related to Selecting and Serving as a Service Recipient's "Representative Payee": In accordance with TennCare policy which specifies provider requirements related to personal funds management, provider responsibilities include:

- 1) Making a reasonable effort to identify a responsible "Representative Payee" who is a family member or friend;
- 2) Agreeing to serve as a service recipient's "Representative Payee" only if another responsible party cannot be identified;
- 3) Refraining from requiring an enrollee to designate the provider as "Representative Payee" for any reason, including requiring such designation as a condition of providing services;
- 4) Refraining from charging a funds management fee when selected as a service recipient's "Representative Payee"; and

- 5) Including the name of the legal representative and the circumstances of appointment on the Social Security Administration application form (Form SSA-11, page 1, item 5) so the legal representative may be contacted if necessary.

6.10.d. Requirement for Development of Personal Funds Management Policies: In accordance with TennCare policy, providers, including providers of paid conservatorship services, who assist in management of personal funds or manage personal funds on behalf of any service recipient shall develop and implement written policies and procedures to protect personal funds. Policies shall indicate that the ISP will specify the extent to which a provider is entrusted with management of personal funds.

6.10.e. Provider Prohibitions Related to Personal Funds Management: Provider prohibitions include:

- 1) Providers and their employees, representatives, and subcontractors and paid conservators are prohibited from illegally obtaining or otherwise misusing personal funds, including but not limited to:
 - Borrowing personal funds from the service recipient;
 - Using a service recipient's personal funds for staff benefit (e.g., purchasing premium cable channels for staff entertainment or purchasing tickets for staff attendance to activities or events selected based on staff preference rather than the service recipient's preference);
 - Using a service recipient's personal funds for provider benefit such as using service recipient funds to pay for maintenance or repair of property such as buildings, building grounds, equipment, or appliances owned by the provider, for telephone charges other than those attributed to the service recipient's personal phone use, or for office space intended for provider use;
 - Using one enrollee's funds for the benefit of another person;
 - Using personal funds for any medical supplies, services or equipment covered by TennCare, Medicaid, Medicare or other health insurance;
 - Giving or withholding an enrollee's personal funds for the purpose of rewarding or punishing the enrollee unless specifically approved by a human rights committee and specified in the Independent Support Plan; and
 - Otherwise using an enrollee's personal funds for purposes that do not benefit the enrollee;
- 2) Providers are prohibited from commingling personal funds belonging to different service recipients;
- 3) Providers are prohibited from allowing negative bank balances to occur for service recipient accounts;

- 4) Providers are prohibited from the purchase of insurance policies with service recipient funds when the insurance policies are not for the sole benefit of the enrollee; and
- 5) Providers are prohibited from requiring the purchase of home liability insurance policies as a condition of receiving services.

6.10.f. Provider Requirements Pertaining to Personal Funds Management: Provider requirements include:

- 1) Providers will reimburse service recipients for telephone or other utility expenses attributable to agency administrative use;
- 2) Providers will have written policies addressing how personal funds will be maintained, secured and safeguarded, including limitations on staff access to personal funds;
- 3) Providers will ensure that individual personal allowances kept in the home are maintained separately and are not treated as household petty cash (If a single locked box is used, the personal allowances must be kept in separate labeled envelopes within the box.);
- 4) Providers will ensure that separate ledgers are kept for each service recipient, including beginning and ending balances for each month and description of any expenditures (with supporting receipts for expenditures exceeding \$4.99);
- 5) Providers will ensure maintenance of separate bank accounts for each service recipient;
- 6) Providers will ensure documentation of monthly reconciliation of bank statements, checks and deposits;
- 7) Providers will ensure timely reimbursement (not to exceed thirty (30) calendar days) to the service recipient following identification of a financial loss to the service recipient caused by the action or inaction of the provider or the provider's employee, representative or subcontractor, including but not limited to:
 - Loss of Social Security funds due to the provider's negligence in allowing countable assets to exceed the countable asset limit;
 - Payment of bank fees for insufficient funds that result from provider negligence;
 - Late payment penalties to utilities; and
 - Payment of expenses that do not directly benefit the enrollee;
- 8) Providers will develop and implement adequate accounting procedures for management of service recipients' personal funds to assure consistent availability of current information involving:
 - The amount of financial resources available to each service recipient for basic living expenses and for personal spending;

- The amount of total countable assets (For Medicaid funded service recipients, personal assets exceeding maximum resource limits must be reported to the Department of Human Services); and
 - Documentation (e.g., receipts, monthly billings, checkbook ledgers) of expenditures made on behalf of the service recipient, including justification that the purchase was appropriate and in accordance with the service recipient's needs;
- 9) Providers will ensure that service recipient protections are developed and implemented to prevent improper expenditures of personal funds for insurance policies;
- 10) Providers will ensure that all personal funds and personal property are appropriately inventoried or accounted for, including:
- Initial inventories of personal property compiled as of the date the provider began providing services;
 - Timely updating of inventories of personal property to indicate personal property removed from or brought into the home, including dated signatures of the individuals who purchased or supplied the personal property; and
 - Timely updating of personal fund or personal allowance ledgers to indicate funds provided to the service recipient by others, including dated signatures of the individuals who supplied the funds;
- 11) Providers will ensure that personal property and personal funds are efficiently and effectively transferred in a timely manner to the new provider when a change of providers occurs (e.g., due to provider agency closure), including but not limited to the following:
- The transferring provider shall reconcile records pertaining to personal funds management (e.g., personal allowance ledgers for petty cash, checkbooks, etc.);
 - Except as otherwise required by social security requirements, the transferring provider shall forward any personal allowance cash balances to the receiving provider within five (5) business days (If the 5th working day falls on a state or federal holiday, transfers shall be completed on the next business day.);
 - The transferring provider shall provide the receiving provider with an inventory of the enrollee's personal property, as well as the actual personal property if a change in location is necessary;
 - The receiving provider shall conduct an initial inventory of all personal property received and shall immediately notify the transferring provider and the support coordinator/case manager if there are any discrepancies between personal property received and personal property noted on the transferring provider's inventory;

- Except as otherwise required by the Social Security Administration, the receiving provider shall complete arrangements to transfer benefit payments (e.g., food stamp payments) within five (5) business days (If the 5th working day falls on a state or federal holiday, transfers must be completed on the next business day.); and
- If applicable, the receiving provider must complete and submit documents necessary to establish the receiving provider as the representative payee within thirty (30) calendar days (If the 30th day falls on a federal holiday, submission may occur on the next business day.).

6.11. Implementation of the Individual Support Plan (ISP)

Providers are required to implement the ISP, including ensuring staff training as needed to ensure appropriate implementation. Providers who employ direct support staff are required to ensure that such staff implement any staff instructions necessary to the completion of ISP action steps or achievement of ISP outcomes, even if such staff instructions are primarily written by other providers (i.e. therapists or behavior service providers). It is expected that when staff instructions are determined necessary, providers will collaborate/cooperate in developing staff instructions and providing training/support to ensure that staff appropriately implement the instructions provided. Providers are required to document implementation of the ISP, including progress in completing action steps and achieving outcomes. Providers are expected to take advantage of “teachable moments” that occur during the course of daily life. Teachable moments are opportunities to include the service recipient in meaningful activities that occur throughout the day that may or may not be detailed in the ISP. Examples of such activities may include assisting staff to prepare meals or plan menus, assisting staff with household duties such as washing clothing or helping to schedule activities.

6.12. Notification of DMRS of Changes in Provider Information

Providers are required to notify the DMRS Central Office of :

- 1) Change in provider office address, telephone or fax numbers;
- 2) Change of provider chief administrative officer;
- 3) Change of Board chair;
- 4) Changes in services offered; and
- 5) Changes of address for service recipients (applicable only to the provider identified as being the primary provider).

6.13. Electronic/Computer Capability Requirements and Considerations

6.13.a. Provider Requirements: It is DMRS' intention to conduct business with providers through electronic means to the extent possible. Consequently, providers are required to:

- 1) Maintain e-mail accounts that, at minimum, is accessible to the executive director/chief executive officer and Board Chair (if applicable);
- 2) Have access to the internet, at least at the provider's administrative office(s);
- 3) Provide basic computer skills training to any staff who will be expected to communicate electronically or provide or access electronic information to or from DMRS;
- 4) Submit required reports, data, forms, billing documents and other information electronically through business applications/systems provided or designed by DMRS; and
- 5) Maintain an electronically secure environment in compliance with the Security Rule of HIPAA (CFR, Title 45, Parts 106 and 164), including ensuring that email communications and attachments containing personal health information are encrypted when transmitted across the Internet.

6.13.b. Electronic Signatures: Electronic signatures are not acceptable at this time on records pertaining to service recipients enrolled in a Medicaid waiver.