



April 25, 2018

Ms. Krista Lee, Executive Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

RE: TennCare Amendments (6) for Fiscal Review Consideration

Dear Ms. Lee:

The Department of Finance and Administration, Division of TennCare, is submitting for consideration by the Fiscal Review Committee the following four (4) Managed Care Organization (MCO) amendments, one (1) service contract amendment, and (1) purchase of software license.

- (1) AMERIGROUP Tennessee, Inc. (Edison # 40180, amendment #8)
- (2) UnitedHealthcare Plan of the River Valley, d/b/a UnitedHealthcare Community Plan (Edison # 40181, amendment #8)
- (3) Volunteer State Health Plan, Inc. d/b/a Blue Care Tennessee (Edison # 40197, amendment #8)
- (4) Volunteer State Health Plan, TennCare Select (Edison # 29635, Amendment #43)

These managed care contracts are being amended to provide relative changes to the managed care program including: (1) addition of Dignity of Risk and Supported Decision-Making requirements to PCSP development process; (2) incorporates 21st Century Cures Act requirements for EVV System; (3) addition of language for initiation of services requirements as requested by MCOs; (4) language clarification regarding 1915c HCBS Waiver transfers; (5) addition of Change of Ownership (CHOW) process requirements for ECF CHOICES Providers and CLS/CLS-FM Providers; (6) clarification on when critical incidents and reportable events 24-hour reporting timeframe begins; (7) provide access standards for Opioid Use Disorder; (8) include travel time access in accordance with Managed Care Regulations; (9) extends Contract Term and increase maximum liability to cover term extension; (10) updates Cap Rate to reflect current rates, (does not apply to VSHP Select) and (11) contract housekeeping (Definitions, Reporting, etc.).

- (5) Cognosante Consulting, LLC (Edison # NV3-37266, amendment #4) - This competitively procured contract is for the provision of Independent Validation and Verification (IV&V) services for the Medicaid Modernization Program. The purpose of this contract amendment is to provide term extension pursuant to approved Rule Exception Request #cy17-8451 and funding to support this extended period of time. The continuation of this contract is crucial to the continuation of IV&V support through the current TennCare Eligibility Determination System (TEDS) implementation. Additionally, this term extension will align with the Medicaid Management Information System (MMIS) modularization, and strategic HITECH Initiatives.

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IV&V's direct project participation and oversight has been expanded and is required by CMS to allow TennCare to qualify for enhanced funding for the aforementioned system implementation areas.

- (6) Serena Software, Inc. (Edison #53052, amendment #1) - This contract between TennCare and Serena Software was created to provide maintenance services for several different types of Serena-issued licenses purchased by the State prior to the contract. At the time of procurement for these maintenance services there was no indication that any additional licenses would be needed in the future. Due to the growth within TennCare, the need for additional licenses has been re-evaluated. The amendment of this purchase contract will provide the option to purchase new licenses on contract in the future, along with maintenance to support each license.

TennCare respectfully submits the above referenced contract amendments for consideration and approval by the Fiscal Review Committee. We look forward to promptly providing any additional information as may be requested by the Committee.

Sincerely,



William Aaron
Chief Financial Officer

cc: Wendy Long, M.D., Deputy Commissioner

Amendment Request

This request form is not required for amendments to grant contracts. Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprrs.Agsprsr@tn.gov

APPROVED	
Kevin C. Bartels for Michael F. Perry	Digitally signed by Kevin C. Bartels for Michael F. Perry DN: cn=Kevin C. Bartels for Michael F. Perry, o=CPO, ou, email=Kevin.C.Bartels@tn.gov, c=US Date: 2018.04.16 13:39:24 -05'00'
CHIEF PROCUREMENT OFFICER	DATE

Agency request tracking #	31865-00372
1. Procuring Agency	Department of Finance and Administration Division of Health Care Finance and Administration
2. Contractor	AMERIGROUP Tennessee, Inc.
3. Edison contract ID #	40180
4. Proposed amendment #	8
5. Contract's Effective Date	January 1, 2014
6. Current end date	December 31, 2018
7. Proposed end date	December 31, 2019
8. Current Maximum Liability or Estimated Liability	\$7,815,423,650.00
9. Proposed Maximum Liability or Estimated Liability	\$9,815,423,650.00
10. Office for Information Resources Pre-Approval Endorsement Request <i>- Information technology service (N/A to THDA)</i>	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached
11. eHealth Pre-Approval Endorsement Request <i>- health-related professional, pharmaceutical, laboratory, or imaging</i>	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached
12. Human Resources Pre-Approval Endorsement Request <i>- state employee training service</i>	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached

Agency request tracking #

31865-00372

13. Explain why the proposed amendment is needed:

This competitively procured contract is being amended to provide relative changes to the managed care program including: (1) addition of Dignity of Risk and Supported Decision-Making requirements to PCSP development process; (2) incorporates 21st Century Cures Act requirements for EVV System; (3) addition of language for initiation of services requirements as requested by MCOs; (4) language clarification regarding 1915c HCBS Waiver transfers; (5) addition of Change of Ownership (CHOW) process requirements for ECF CHOICES Providers and CLS/CLS-FM Providers; (6) clarification on when critical incidents and reportable events 24-hour reporting timeframe begins; (7) provide access standards for Opioid Use Disorder; (8) include travel time access in accordance with Managed Care Regulations; (9) extends Contract Term and increase maximum liability to cover term extension; (10) updates Cap Rate to reflect current rates, and (11) contract housekeeping (Definitions, Reporting, etc.).

14. If the amendment involves a change in Scope, describe efforts to identify reasonable, competitive, procurement alternatives to amending the contract.

This contract for the provision of medical and behavioral health services to the TennCare population was competitively procured. These changes to scope are necessary to make updates to the contract based on contract program changes to existing language and to ensure compliance with CMS regulations.

Signature of Agency head or authorized designee, title of signatory, and date (the authorized designee may sign his or her own name if indicated on the Signature Certification and Authorization document)



4/13/18



CONTRACT AMENDMENT COVER SHEET

Agency Tracking # 31865-00372	Edison ID 40180	Contract #	Amendment # 08
Contractor Legal Entity Name AMERIGROUP Tennessee, Inc.			Edison Vendor ID 0000011035
Amendment Purpose & Effect(s) Extends Term One Year, Increases Maximum Liability			
Amendment Changes Contract End Date: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		End Date: December 31, 2019	
TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A):			\$ 2,000,000,000.00
Funding —			
FY	State	Federal	TOTAL Contract Amount
2014	\$0.00	\$0.00	\$0.00
2015	\$324,807,988.00	\$602,949,762.00	\$927,757,750.00
2016	\$660,871,832.00	\$1,226,794,068.00	\$1,887,665,900.00
2017	\$700,340,000.00	\$1,299,660,000.00	\$2,000,000,000.00
2018	\$687,900,000.00	\$1,312,100,000.00	\$2,000,000,000.00
2019	\$682,840,000.00	\$1,317,160,000.00	\$2,000,000,000.00
2020	\$341,420,000.00	\$658,580,000.00	\$1,000,000,000.00
TOTAL:	\$3,398,179,820.00	\$6,417,243,830.00	\$9,815,423,650.00
American Recovery and Reinvestment Act (ARRA) Funding: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations. 		CPO USE	
Speed Chart (optional)		Account Code (optional)	

**AMENDMENT NUMBER 8
STATEWIDE CONTRACT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
AMERIGROUP TENNESSEE, INC.**

EDISON RECORD ID: 40180

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contract by and between the State of Tennessee, Division of TennCare, hereinafter referred to as TENNCARE, and AMERIGROUP TENNESSEE, INC., hereinafter referred to as the CONTRACTOR as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. **The terms "comprehensive needs assessment" and "needs assessment" as they relate to CHOICES and ECF CHOICES shall be replaced with "comprehensive assessment" throughout.**
2. **Number 11 in the Definition for "Administrative Cost" shall be amended by deleting the word "Complaint" and replacing it with the word "Grievance".**
3. **The following Definitions shall be amended as follows:**

Benefit Appeal – As distinguished from an Eligibility Appeal, a "Benefit Appeal" concerns an enrollee's request to contest an MCC's adverse benefit determination by receiving a State Fair Hearing (SFH). CMS has determined that the provisions contained in 42 C.F.R. 438 subpart F, which require MCOs to maintain an internal appeal system, and which require enrollees to exhaust the MCO internal appeal process before being permitted to request a SFH, are satisfied by TENNCARE's requirement that the CONTRACTOR comply with the "Reconsideration" phase of the state fair hearing process (also called the "appeal process"). In accordance with CMS approval, the CONTRACTOR shall not have an internal appeal process that enrollees are required to exhaust before they may request a SFH through the TENNCARE appeal process. The CONTRACTOR's "Reconsideration" of its initial adverse benefit determination during the TENNCARE appeal process is deemed by CMS to satisfy the requirement for a MCO-level appeal.

Benefit Appeal System – Synonymous with State Fair Hearing (SFH) System, SFH Process, Appeal System, and Appeal Process. References to Appeal System or Appeal Process refers to both (1) the *processes* the CONTRACTOR implements to comply with its TENNCARE Appeal Process-related obligations (such as timely issuance of a compliant Notice of Adverse Benefit Determination (NABD), timely compliance with the Reconsideration phase of the Appeal Process, timely compliance with TENNCARE-issued directives instructing CONTRACTOR to approve and arrange provision of a benefit in accordance with an Order resulting from the Appeal Process, etc.), and (2) the processes the CONTRACTOR implements to collect, track and maintain the information gathered in accordance with the Appeal Process.

Benefits – The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to TennCare enrollees assigned to the CONTRACTOR's MCO pursuant to this Contract.

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including CHOICES HCBS and Medicaid reimbursed home health and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy. A member’s individual cost neutrality cap shall be the average cost of Level 1 nursing facility care, or upon implementation of the new nursing facility reimbursement methodology, the average cost of nursing facility care (the Level 1/Level 2 distinction will be eliminated), unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care application, because the member would qualify to receive Enhanced Respiratory Care reimbursement in a nursing facility.

Electronic Visit Verification (EVV) System – An electronic system that meets the minimum functionality requirements prescribed by TENNCARE which provider staff must use to check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of specified CHOICES and ECF CHOICES HCBS and which may also be utilized for submission of claims. Any such system shall comply with the 21st Century Cures Act.

Grievance System – The processes the CONTRACTOR implements to handle grievances, as well as the processes to collect and track information about them. See 42 C.F.R. §438.400(b).

Presumptive Eligibility – An established period of time during which certain pregnant women are eligible for TennCare Medicaid. During this period of time the presumptively eligible enrollee must complete a full application for Medicaid in order to stay on the program. Eligibility extends from the presumptive eligibility effective date through the end of the following month unless a full Medicaid application is completed. When a full Medicaid application is completed, presumptive eligibility is provided until an eligibility determination is made on the full Medicaid application.

Reconsideration - mandatory component of the TENNCARE Benefit Appeal Process by which an MCO reviews and renders a decision affirming or reversing the adverse benefit determination at issue in the enrollee’s request for SFH. An MCO satisfies the plan-level requirements of 42 C.F.R. 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding.

State Fair Hearing (SFH) – The Benefit Appeal Process set forth in subpart E of part 431 chapter IV, title 42 under which TennCare enrollees have the right to request a SFH (synonymous with “Appeal”) to contest MCC-proposed Adverse Benefit Determinations. CoverKids/CHIP program enrollees do not have the right to receive a SFH, but may receive a CoverKids “Review”. See 42 CFR §438.400(b).

Transition Allowance – A per member allotment not to exceed two thousand dollars (\$2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided to a CHOICES or ECF CHOICES member as a cost-effective alternative to continued institutional care for which the CONTRACTOR is responsible for payment (e.g., a nursing facility or inpatient psychiatric care at a Regional Mental Health Institute) in order to facilitate transition to the community. The allotment is only appropriate when such a member will, upon transition, will receive more cost-effective home and community based services either non-residential services or consumer directed companion care in their own home, residential services in a non-provider owned residential setting, or for limited items, as specified below in this section, in provider-owned residential settings. Provider-owned settings include settings in which the provider owns, co-owns, or has any affiliation with the entity that owns the home in which the member will reside. A Transition Allowance may also be provided as a cost-effective alternative when a member must transition out of the current living

arrangement and would, but for the availability of the Transition Allowance, require placement in a medical institution for which the CONTRACTOR is responsible for payment, as stated above. The CONTRACTOR shall only be responsible for payment of nursing facility services when the person meets nursing facility level of care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain (including community resources that the CONTRACTOR is expected to assist the member in accessing first) and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes. In provider-owned settings, the transition allowance shall only be used for household items and furnishings that are for the member's personal use, such as bedroom furniture, towels, linens, sheets, and other similar items as approved by TennCare. In provider-owned settings, a transition allowance shall not be used for rent or utility deposits or for household items and furnishings for common use of all persons residing in the home. Regardless of setting, items purchased as part of the Transition Allowance shall be the personal property of the member, not the provider.

4. The Definition of "Complaint" shall be deleted.

5. Sections A.2.7.6.2.4 and A.2.7.6.2.8.2 shall be deleted and replaced as follows:

2.7.6.2.4 As part of its TennCare Kids policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up shall include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least two (2) efforts per year in excess of the six (6) "outreach contacts" to get the member in for a screening. The efforts shall be in different formats. -

2.7.6.2.8.2 The CONTRACTOR shall conduct screening events through each region it serves to ensure all members have reasonable access to events during a Federal Fiscal Year. Results of the CONTRACTOR's or STATE's CMS 416 report, as well as county demographics, shall be utilized in determining counties for targeted activities and in developing strategies for specific populations, particularly members who have limited English proficiency, low literacy levels, behavioral health needs, special health care needs or who are pregnant.

6. Section A.2.9.2.1.4.1 shall be amended as follows:

2.9.2.1.4.1 For a member in CHOICES Group 2 or 3 or ECF CHOICES, the CONTRACTOR shall continue CHOICES or ECF CHOICES HCBS authorized by the transferring MCO for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce these services unless a Care Coordinator or Support Coordinator, as applicable, has conducted a comprehensive needs assessment and developed a plan of care or PCSP, and the CONTRACTOR has authorized and initiated CHOICES or ECF CHOICES HCBS in accordance with the member's new plan of care or PCSP. If a member in CHOICES Group 2 or 3 or ECF CHOICES is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14). For a member in Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14); however, the member may be transitioned to the community in accordance with Section A.2.9.6.8 of this Contract.

7. Section A.2.9.3.3 shall be amended as follows:

2.9.3.3 For members in CHOICES Groups 2 and 3 the CONTRACTOR shall continue HCBS in the member's approved PCSP for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce HCBS unless the member's Care Coordinator has conducted a comprehensive needs assessment and developed a PCSP and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new PCSP. If a member in CHOICES Groups 2 or 3 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14).

8. Section A.2.9.4 shall be amended by deleting and replacing Sections A.2.9.4.1.1.4.5, A.2.9.4.1.1.4.6, A.2.9.4.1.2.4, A.2.9.4.1.3.4, A.2.9.4.1.3.5.3, A.2.9.4.1.4.3, A.2.9.4.1.4.3.1, A.2.9.4.1.4.4, and A.2.9.4.1.4.5.7 as follows:

2.9.4.1.1.4.5 Provide education on ECF CHOICES and CHOICES programs, unless the member is enrolled in a Section 1915(c) HCBS waiver;

2.9.4.1.1.4.6 Assist, as needed with referral and intake/enrollment processes, as applicable for CHOICES or ECF CHOICES, unless the member is enrolled in a Section 1915(c) HCBS waiver and in such case, only as referred by TENNCARE.

2.9.4.1.2.4 Coordinate joint interdisciplinary face-to-face in-home visit including but not limited to the HH or PDN care coordinator and ECF CHOICES and CHOICES Care and Support Coordinator Team or Advocate unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the joint interdisciplinary face-to-face in-home visit shall be coordinated to include the member's Independent Support Coordinator rather than the ECF CHOICES and CHOICES Care and Support Coordinator Team.

2.9.4.1.3.4 Coordinate joint interdisciplinary face-to-face in-home visit including but not limited to the HH or PDN care coordinator and ECF CHOICES and CHOICES Care and Support Coordinator Team or Advocate unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the joint interdisciplinary face-to-face in-home visit shall be coordinated to include the member's Independent Support Coordinator rather than the ECF CHOICES and CHOICES Care and Support Coordinator Team.

2.9.4.1.3.5.3 Determine and document member's initial preference or potential changes to the member's support plan/environment when turning twenty-one (21) and update ECF CHOICES person-centered support plan if already enrolled unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the CONTRACTOR shall work with the Independent Support Coordinator to update the member's Individual Support Plan.;

2.9.4.1.4.3 Re-evaluate all members and confirm if member is considering CHOICES or ECF CHOICES, unless the member is enrolled in a Section 1915(c) HCBS waiver.

2.9.4.1.4.3.1 For members receiving HH or PDN services above the adult benefit limit and/or coverage criteria considering home and community based services CHOICES or ECF CHOICES the CONTRACTOR shall contact LTSS within five (5) business days of discovery that a member

is above such limit and/or coverage criteria to discuss transition of the member, unless the member is enrolled in a Section 1915(c) HCBS waiver. This shall include but is not limited to discussing and initiating the intake process for CHOICES or ECF CHOICES. For CHOICES group 2 or 3, the member cannot enroll until age twenty-one (21) but the MCO can complete a person-centered support plan (PCSP) with the member/family to demonstrate what services will be provided. For ECF CHOICES, enrollment can occur earlier and allows the member to initiate some ECF CHOICES services and also begin the process of hiring CD workers if they choose that option.

2.9.4.1.4.4 For members not considering home and community based CHOICES or ECF CHOICES and not enrolled in a Section 1915(c) HCBS waiver, Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID):

2.9.4.1.4.5.7 Considering CHOICES/ECF CHOICES (Yes/No)—note that if the member is enrolled in a Section 1915(c) HCBS waiver, the answer is expected to be “No”. If a member is enrolled in a 1915(c) HCBS Waiver and has a need for supports not available in that Waiver or requests transition to CHOICES or ECF CHOICES, the CONTRACTOR shall refer the member to TENNCARE for transition as appropriate;

9. Section A.2.9.6 shall be amended by deleting and replacing Sections A.2.9.6.2.3.9, A.2.9.6.2.5.3, A.2.9.6.2.5.3.2, A.2.9.6.2.5.3.3, A.2.9.6.2.5.3.4, A.2.9.6.3.16, A.2.9.6.3.26, A.2.9.6.3.26.2, A.2.9.6.3.27 as well as renumbered Sections A.2.9.6.3.26.3, A.2.9.6.3.26.3.1, A.2.9.6.3.26.3.2, A.2.9.6.3.26.4, deleting existing Section A.2.9.6.3.26.3, and renumbering the remaining section, including any references thereto.

2.9.6.2.3.9 As part of the enrollment visit for ECF CHOICES, TENNCARE or its designee shall, as applicable (see 2.9.6.2.3.8.1) and in accordance with requirements set forth in protocol: (1) confirm or update, as applicable, the applicant’s current address and phone number(s); (2) review ECF CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (3) make sure the applicant is aware that DIDD policy does not permit a person enrolled in ECF CHOICES to enroll in the Family Support Program operated by DIDD; (4) complete level of care (i.e., PAE) and Medicaid applications and provide assistance, as necessary, in gathering documentation needed by the State to determine medical and financial eligibility for reimbursement of LTSS, including post-eligibility provisions (i.e., patient liability); (5) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (6) provide information about estate recovery; (7) provide detailed information and obtain signed acknowledgement of understanding regarding an ECF CHOICES member’s responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability; (8) provide information regarding consumer direction and obtain signed documentation of the applicant’s interest in participating in consumer direction; and (9) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in ECF CHOICES and the functions of the CONTRACTOR upon enrollment, including that the CONTRACTOR shall work with the applicant to develop and approve a PCSP. The enrollment visit shall be face-to-face, except in circumstances described in A.2.9.6.2.3.7 where TENNCARE’s designee has already completed actions required as part of the enrollment process and obtained the required signatures during the face-to-face intake visit, in which case TENNCARE’s designee may proceed with enrollment, and shall contact the ECF CHOICES applicant either in person or telephonically within five (5) business days of the decision to proceed with enrollment to inform the applicant that TENNCARE’s designee shall be completing and submitting the PAE on the applicant's behalf, and will

explain that the applicant will receive the outcome of this submission from TENNCARE via mail.

- 2.9.6.2.5.3 For CHOICES and ECF CHOICES members, the Support Coordinator or Care Coordinator, as applicable, shall conduct a face-to-face visit with the member, initiate a comprehensive assessment in a manner sufficient to ensure strengths, needs, opportunities, and challenges are identified and addressed as set forth below, and conduct a caregiver assessment, and authorize and initiate CHOICES HCBS and ECF CHOICES HCBS as described and in accordance with timeframes specified in this section.
- 2.9.6.2.5.3.2 For ECF CHOICES members, the CONTRACTOR shall determine if the member immediately needs any ECF CHOICES HCBS while the comprehensive PCSP is developed. Immediately needed ECF CHOICES HCBS may include (but are not limited to) services that a person needs in order to facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting, to prevent imminent placement outside the person's current living arrangement, to address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm, or consistent with the program's primary goals, to prevent imminent loss of competitive integrated employment or an offer of such employment. The CONTRACTOR may utilize other covered benefits or cost-effective alternative services as needed to address immediate needs while ECF CHOICES services are put into place, or provide incentives to providers with prior approval from TENNCARE to provide such immediately needed services and to put in place sustainable strategies to enable the provider to do so on ongoing basis. The CONTRACTOR shall document immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs in the PCSP and shall authorize and initiate any immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs within ten (10) business days of receiving notice of a member's enrollment, or as expeditiously as needed to facilitate timely discharge, avoid inappropriate placement, or to avoid imminent loss of competitive integrated employment or an offer of such employment. In the case of immediately needed ECF CHOICES HCBS, initiation shall include the commencement of the actual provision of services (or other covered benefits or cost-effective alternative services). Any ECF CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed shall continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly. For ECF CHOICES members who were enrolled under one of the employment-related priority categories, the development of the person centered support plan process shall first address, the goals and support/service needs specific to the employment-related priority category through which the member gained enrollment into the program.
- 2.9.6.2.5.3.3 The PCSP shall identify all CHOICES HCBS and ECF CHOICES HCBS that are needed, including those services that are immediately needed upon enrollment or other covered benefits or cost-effective alternative services to address immediate needs and those services identified through the person-centered planning process that are needed to help members achieve their goals across all domains of the PCSP.
- 2.9.6.2.5.3.4 The Support Coordinator or Care Coordinator, as applicable, shall, within thirty (30) calendar days of notice of enrollment in CHOICES or ECF CHOICES, complete the comprehensive assessment (see A.2.9.6.5.2.5), develop the PCSP, and authorize and initiate services as specified in the PCSP, except when a later date, for one or more specified services, is requested by the member which shall be documented in writing in the manner prescribed by

TennCare, including but not limited to, (1) when an ECF CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim; or (2) a member requests additional time to complete person-centered planning processes, select a provider and/or staff that are best aligned with his or her goals, needs, and preferences, or visit and select from available options or develop a Community Living Supports living arrangement. In non-urgent circumstances, which shall be distinct from those described in A.2.9.6.2.5.3.2, “initiation” may also take into account the time required by the selected provider to hire and train qualified staff if the CONTRACTOR has informed the member of any providers with existing trained staff available to initiate the service and the member has declined those providers. In this case, services shall be considered “initiated” if a provider has been selected by the member, the services have been authorized by the CONTRACTOR, the provider has agreed to provide the requested service(s), and the CONTRACTOR verifies that the provider is actively engaged in hiring and/or training staff to provide the requested services. The CONTRACTOR shall be responsible for ongoing follow-up with the provider selected by the member to ensure that these processes are completed timely and services commence. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of risk and supported decision-making. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential negative outcomes associated with risks that may result from the member’s decisions, and strategies to mitigate potential negative outcomes associated with identified risks, which shall be documented in the PCSP as appropriate.

2.9.6.3.16 As part of the enrollment visit for ECF CHOICES, the CONTRACTOR shall, as applicable (see 2.9.6.3.15.1.) and in accordance with requirements set forth in protocol: (1) confirm or update, as applicable, the member’s current address and phone number(s); (2) review ECF CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (3) make sure the member is aware that DIDD policy does not permit a person enrolled in ECF CHOICES to enroll in the Family Support Program operated by DIDD; (4) complete the level of care (i.e., PAE) application and provide assistance, as necessary, in gathering documentation needed by the State to determine medical and financial eligibility for reimbursement of LTSS, including post-eligibility provisions (i.e., patient liability); (5) provide information about estate recovery; (6) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member’s responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability; (7) provide information regarding consumer direction; and (8) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in ECF CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will work with the applicant to develop and approve a PCSP.

2.9.6.3.26 For CHOICES and ECF CHOICES members, the Support Coordinator or Care Coordinator, as applicable, shall complete a comprehensive assessment in a manner sufficient to ensure strengths, needs, opportunities, and challenges are identified and addressed in the PCSP, and conduct a caregiver assessment, and authorize and initiate CHOICES HCBS and ECF CHOICES HCBS as described and in accordance with timeframes specified in this section.

2.9.6.3.26.2 For ECF CHOICES members, the CONTRACTOR shall determine if the member immediately needs any ECF CHOICES HCBS while the comprehensive PCSP is developed. Immediately needed ECF CHOICES HCBS may include but are not limited to services that a person needs in order to facilitate timely discharge from an inpatient setting or to prevent

inappropriate placement in an inpatient or other restrictive setting, to prevent imminent placement outside the person's current living arrangement, to address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm, or consistent with the program's primary goals, to prevent imminent loss of competitive integrated employment or an offer of such employment. The CONTRACTOR may utilize other covered benefits or cost-effective alternative services as needed to address these immediate needs while ECF CHOICES services are put into place or provide incentives to providers with prior approval from TENNCARE to provide such immediately needed services and to put in place sustainable strategies to enable the provider to do so on ongoing basis. The CONTRACTOR shall document immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs in the PCSP and shall authorize and initiate any immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs within ten (10) business days of receiving notice of a member's enrollment or as expeditiously as needed to facilitate timely discharge or avoid inappropriate placement, or to avoid imminent loss of competitive integrated employment or an offer of such employment. In the case of immediately needed ECF CHOICES HCBS, initiation shall include the commencement of the actual provision of services (or other covered benefits or cost-effective alternative services). Any ECF CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed shall continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly. For ECF CHOICES members who were enrolled under one of the employment-related priority categories, the development of the person centered support plan process shall address first, the goals and support/service needs specific to the employment-related priority category through which the member gained enrollment into the program.

- 2.9.6.3.26.3 The Support Coordinator or Care Coordinator, as applicable, shall, within thirty (30) calendar days of notice of enrollment in CHOICES or ECF CHOICES, complete the comprehensive assessment (see A.2.9.6.5) and develop the PCSP and authorize and initiate services as specified in the PCSP except when a later date is requested, for one or more specified services, by the member which shall be documented in writing (e.g.,,, these shall include but are not limited to, (1) when an ECF CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim, or (2) a member requests additional time to complete person-centered planning processes, select a provider and/or staff that are best aligned with his or her goals, needs, and preferences, or visit and select from available options or develop a Community Living Supports living arrangement. In non-urgent circumstances, which shall be distinct from those described in 2.9.6.2.5.3.2, "initiation" may also take into account the time required by the provider to hire and train qualified staff if the CONTRACTOR has informed the member of any providers with existing trained staff available to initiate the service and the member has declined those providers. In this case, services shall be considered "initiated" if a provider has been selected by the member, the services have been authorized by the CONTRACTOR, the provider has agreed to provide the requested service(s), and the CONTRACTOR verifies that the provider is actively engaged in hiring and/or training staff to provide the requested services. The CONTRACTOR shall be responsible for ongoing follow-up with the provider selected by the member to ensure that these processes are completed timely and services commence. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of risk and supported decision-making. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential negative outcomes associated with risks that may result from the member's decisions, and strategies to mitigate

potential negative outcomes associated with identified risks, which shall be documented in the PCSP as appropriate.

2.9.6.3.26.3.1 In developing the PCSP for ECF CHOICES, the Support Coordinator shall ensure that the Employment Informed Choice Process is followed.

2.9.6.3.26.3.1.1 Upon completion of Exploration services, if the member elects not to pursue Individualized Integrated Employment or Self-Employment, the Support Coordinator shall obtain signed acknowledgement from the member/representative before Community Integration Support Services and/or Independent Living Skills Training may continue or be newly authorized. The signed acknowledgement is to be obtained after the Support Coordinator meets with the individual and involved family, guardian, or conservator, if applicable, to review results of Exploration services and the Exploration report and provide re-education or additional education on the benefits of employment and supports available for employment. If the person still declines to pursue employment, and declines to participate in any employment service, the Support Coordinator shall obtain written confirmation of the person's informed choice not to pursue individualized, integrated employment or Self-Employment at the time. The meeting, including signing of the acknowledgement when applicable, shall occur within thirty (30) calendar days of the CONTRACTOR receiving the completed Exploration report. If Community Integration Support Services and/or Independent Living Skills Training are already authorized, these services may continue until the meeting is held and signed acknowledgement is obtained.

2.9.6.3.26.3.2 The CONTRACTOR shall ensure a seamless transition from (a) CHOICES HCBS or ECF CHOICES HCBS that are immediately needed by the member or other covered benefits or cost-effective alternative services to address immediate needs to (b) CHOICES HCBS or ECF CHOICES HCBS in the PCSP identified through the person-centered planning process that are needed to help people achieve their goals across all domains of the PCSP, including those immediately needed services that are also needed on an ongoing basis, with no gaps in care.

2.9.6.3.26.4 Initiation of the comprehensive assessment and determination of immediately needed services for ECF CHOICES members may, at the CONTRACTOR's discretion, occur during the enrollment visit (i.e., prior to enrollment in ECF CHOICES).

2.9.6.3.27 For the CONTRACTOR's members enrolled into CHOICES Group 2 or Group 3 or ECF CHOICES Groups 4, 5, or 6, the member's Care Coordinator or Support Coordinator, as applicable, shall, within the timeframes prescribed in this section, authorize and initiate CHOICES or ECF CHOICES HCBS, as applicable.

10. Section A.2.9.6 shall be amended by amending and deleting Sections A.2.9.6.2.3.11.1, A.2.9.6.2.4.1, A.2.9.6.2.4.4, A.2.9.6.2.4.5, A.2.9.6.3.24.1, and A.2.9.6.3.27.3 as follows:

2.9.6.2.3.11.1 For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and Section A.2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care, or upon implementation of the new nursing facility reimbursement methodology, the average cost of nursing facility care because the Level 1/Level 2 distinction will be eliminated, unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care, because the member would qualify to receive Enhanced Respiratory Care reimbursement in a nursing facility.

- 2.9.6.2.4.1 For members enrolled in CHOICES Group 1, who are, upon CHOICES enrollment, receiving nursing facility services, the CONTRACTOR shall reimburse such services in accordance with the level of reimbursement for nursing facility services approved by TENNCARE (see Section A.2.14.1.14), except that, until the new nursing facility reimbursement methodology is effective in the TennCare Rules, the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement. Reimbursement for such services shall be for the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Group 1 who are, upon CHOICES enrollment, receiving nursing facility services, to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider. If the nursing facility is a non-contract provider, the CONTRACTOR shall (a) provide continuation of the services pending enrollment of the facility as a contract provider, if the provider is eligible for enrollment in Medicaid, and reimburse such services from the non-contract nursing facility in accordance with TennCare rules and regulations; (b) provide continuation of the services pending facilitation of the member's transition to a contract facility and reimburse such services from the non-contract nursing facility in accordance with TennCare rules and regulations, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.
- 2.9.6.2.4.4 For purposes of the CHOICES program, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section A.2.14.1.14), except that, until the new nursing facility reimbursement methodology is effective in the TennCare Rules, the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement.
- 2.9.6.2.4.5 Until the new nursing facility reimbursement methodology is effective in the TennCare Rules, for CHOICES members approved by TENNCARE for Level II reimbursement of nursing facility services, the CONTRACTOR shall be responsible for monitoring the member's continued need for Medicaid reimbursed skilled and/or rehabilitation services, promptly notifying TENNCARE when such skilled and/or rehabilitative services are no longer medically necessary, and for the submission of information needed by TENNCARE to reevaluate the member's level of care (i.e., reimbursement) for nursing facility services (see also Section A.2.14.1.14).
- 2.9.6.3.24.1 For members in CHOICES Group 2 TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section A.1 and see Section A.2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care, or upon implementation of the new nursing facility reimbursement methodology, the average cost of nursing facility care (the Level 1/Level 2 distinction will be eliminated), unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as

applicable) in the level of care, because the member would qualify to receive Enhanced Respiratory Care reimbursement in a nursing facility.

2.9.6.3.27.3 Except as required pursuant to Section A. 2.14.5.8, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section A.2.14.1.14). Until the new nursing facility reimbursement methodology is effective in the TennCare Rules, the CONTRACTOR may however reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement. If the CONTRACTOR elects to authorize nursing facility services, the CONTRACTOR may determine the duration of time for which nursing facility services will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES nursing facility services in accordance with the level of care and/or reimbursement approved by TENNCARE. Retroactive entry or adjustments in service authorizations for nursing facility services should be made only upon notification of retroactive enrollment into or disenrollment from CHOICES Group 1a or 1b via the outbound 834 file from TENNCARE.

11. Section A.2.9.6.5.2.2 shall be amended as follows:

2.9.6.5.2.2 At a minimum, for members in CHOICES Group 2 and 3, the comprehensive assessment shall assess: (1) the member's overall wellness including physical, behavioral, functional, and psychosocial needs; (2) an evaluation of the member's financial health as it relates to the member's ability to maintain a safe and healthy living environment, which for individuals receiving community-based residential alternative services other than companion care, shall include the member's capabilities and desires regarding personal funds management; any training or assistance needed to support the member in managing personal funds or to develop skills needed to increase independence with managing personal funds; and any health, safety or exploitation issues that require limitations on the member's access to personal funds; (3) the member's interest in pursuing integrated, competitive employment and any barriers to pursuing employment (as applicable); (4) the member's opportunities to engage in community life and access community services and activities to the same degree as individuals not receiving HCBS; (5) the member's natural supports, including care being provided by family members and/or other caregivers, and long-term care services the member is currently receiving (regardless of payor), and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver or payor; (6) the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community, delay or prevent the need for institutional placement, and to support the member's individually identified goals and outcomes, including employment (as applicable) and integrated community living; (7) the member's food security, including whether referrals and application assistance for food stamps (i.e., SNAP benefits), WIC (if caring for a minor child), or other public or community resources are appropriate; and (8) the member's need for available assistive technology or any other auxiliary aids or services used to facilitate effective communication.

12. Section A.2.9.6.6.2.3 and A.2.9.6.6.2.4 shall be amended as follows:

2.9.6.6.2.3 The Care Coordinator or Support Coordinator, as applicable, shall verify that the decisions made by the care or support planning team are documented in a written, PCSP, using a template provided by TENNCARE. The CONTRACTOR shall document the PCSP in a format that ensures all content entered is visible and accessible to providers and others to whom the PCSP is distributed, whether viewed electronically or printed. The CONTRACTOR may amend the template format for distribution to providers and other parties, but shall maintain a current version of each member's PCSP in a format prescribed by TENNCARE to facilitate the provision of data to TENNCARE upon request.

2.9.6.6.2.4 When developing the PCSP for CHOICES and ECF CHOICES members, the CONTRACTOR shall comply with federal rules at 42 C.F.R. § 441.301(c) pertaining to person-centered planning and shall use the PCSP template required by TENNCARE. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of risk and supported decision-making. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential negative outcomes associated with risks that may result from the member's decisions, and strategies to mitigate potential negative outcomes associated with identified risks, which shall be documented in the PCSP as appropriate. The PCSP at a minimum shall include:

13. Section A.2.9.6.6.2.6 shall be amended as follows:

2.9.6.6.2.6 The member's Care Coordinator/care coordination or Support Coordinator/support coordination team shall provide a copy of the member's completed comprehensive assessment and plan of care or PCSP, as applicable, including any updates, to the member, the member's representative, as applicable, the member's community-based residential alternative provider, as applicable, and other providers authorized to deliver services to or for the benefit of the member. The member's Care Coordinator/care coordination or Support Coordinator/support coordination team shall further require that: (a) each provider signs the plan of care or PCSP, as applicable, indicating they have reviewed it in its entirety, they understand and agree to provide the services as described and in accordance with the specific goals, preferences and needs of the member, as outlined in the plan of care or PCSP, as applicable and the comprehensive assessment; and (b) each provider receives the fully completed comprehensive assessment and plan of care or PCSP, as applicable, at least two business days prior to the scheduled implementation of services and prior to any change in such services in order to ensure appropriate and timely training of provider staff. The CONTRACTOR shall have mechanisms in place to ensure that such signatures and confirmation of each provider's agreement to provide services occurs within the timeframes specified in A. 2.9.6.3.12, A.2.9.6.3.20, and A.2.9.6.6.2.7, such that a delay in the initiation of services does not result. Electronic signatures shall be accepted for providers who are not present during the care or support planning process or as needed to facilitate timely implementation, including updates to the plan of care or PCSP, as applicable, based on the member's needs.

14. Sections A.2.9.6.13.3 shall be amended as follows:

2.9.6.13.3 The CONTRACTOR shall oversee its selected EVV vendor to ensure the EVV system operates in compliance with this Contract, with policies and protocols established by TENNCARE, and with the requirements of the 21st Century Cures Act. The CONTRACTOR shall notify TENNCARE within five (5) business days of the identification of any issue affecting EVV system operation which impacts the CONTRACTOR's performance of this Contract, including actions that will be taken by the CONTRACTOR to resolve the issue and the specific timeframes within which such actions shall be completed.

15. Section A.2.9.15.3.1 shall be amended as follows:

2.9.15.3.1 If a member receiving home health or private duty nursing services will be subject to a reduction in covered services provided by the CONTRACTOR upon turning twenty-one (21) years of age and the member also receives 1915(c) HCBS Waiver services, the CONTRACTOR, DIDD, and the Independent Support Coordinator (ISC) as applicable shall, pursuant to policies and processes established by TENNCARE, coordinate benefits to implement any changes in 1915(c) HCBS Waiver Services at the same time that MCO services are reduced to ensure as seamless a transition as possible. If a member is enrolled in a 1915(c) HCBS Waiver and has a need for supports not available in that Waiver or requests transition to CHOICES or ECF CHOICES, the CONTRACTOR shall refer that member to TENNCARE for transition as appropriate.

16. Section A.2.12.9.1 shall be deleted and replaced as follows:

2.12.9.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, shall include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties. Signed agreements may include a wet or handwritten signature or valid binding electronic signature as required by the CONTRACTOR. Agreements kept on file in an electronic format must be immediately accessible in a printable version upon request by TENNCARE or any authorized party as described in Section A.2.12.9;

17. Section A.2.12.9.48 shall be amended by adding a “.” after “etc”.

18. Section A.2.12.9.62 shall be deleted and the remaining Section shall be renumbered accordingly, including any references thereto.

19. Section A.2.12.9 shall be amended by adding a new Section A.2.12.9.68 as follows:

2.12.9.68 Require that all staff employed by contracted providers and delivering employment services to ECF CHOICES members obtain certification and training pursuant to TENNCARE guidance and as required for compliance in the ECF CHOICES program.

20. Section A.2.12 shall be amended by deleting and amending Sections A.2.12.10.7, A.2.12.10.20, A.2.12.11.16, and A.2.12.14.14 as follows:

2.12.10.7 Specify the role of the nursing facility provider regarding timely certification and recertification (as applicable) of the member’s level of care eligibility for nursing facility care, and require the nursing facility provider to cooperate fully with the CONTRACTOR in the completion and submission of the level of care assessment;

2.12.10.20 Notwithstanding the requirements provided in Section A.2.11.9.4.1.11, when there is a change of ownership with any Nursing Facility, the new provider shall provide to TENNCARE documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider. The CONTRACTOR shall, subject to the provisions set forth in T.C.A. § 71-5-1412, enter into a provider agreement with the new provider prior to the effective date of the change of ownership. A new provider with a Medicaid ID and a provider agreement with the CONTRACTOR, which shall include, but not be limited to, the assumption of the previous owner’s agreement, a new agreement with the CONTRACTOR, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the

change of ownership. For purposes of nursing facility changes of ownership only, the CONTRACTOR may provisionally credential the new provider based on credentialing completed for the previous provider to enable execution of an agreement prior to the change of ownership. In cases where the CONTRACTOR utilizes provisional credentialing, the CONTRACTOR must subsequently conduct credentialing of the provider in accordance with Section A.2.11.9 of this Contract once the change of ownership process has fully concluded (including any actions related to licensure and/or certification). A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

2.12.11.16 Notwithstanding the requirements provided in Section A.2.11.9.4.1.11, when there is a proposed change of ownership with any CHOICES or ECF CHOICES provider, the new provider shall provide to TENNCARE documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider and any Managed Care Contractor previously contracted with the former owner or operator. CONTRACTOR shall enter into a provider agreement with the new owner/operator. A new provider with a Medicaid ID and an executed contract with the CONTRACTOR, which shall include, but not be limited to, the assumption of the previous owner's contract, a new contract with the CONTRACTOR, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. A new provider with a Medicaid ID, but without an executed contract with the CONTRACTOR, shall be reimbursed eighty percent (80%) from the effective date of the change of ownership, with a retroactive payment to the effective date of the change of ownership of an additional twenty percent (20%) due after the execution of a contract with the CONTRACTOR. A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

2.12.14.14 Notwithstanding the requirements provided in Section A.2.11.9.4.1.11, when there is a proposed change of ownership, the new provider shall provide to TENNCARE documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider and any Managed Care Contractor previously contracted with the former owner or operator. CONTRACTOR shall enter into a provider agreement with the new owner/operator. A new provider with a Medicaid ID and an executed contract with the CONTRACTOR, which shall include, but not be limited to, the assumption of the previous owner's contract, a new contract with the CONTRACTOR, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. A new provider with a Medicaid ID, but without an executed contract with the CONTRACTOR, shall be reimbursed eighty percent (80%) from the effective date of the change of ownership, with a retroactive payment to the effective date of the change of ownership of an additional twenty percent (20%) due after the execution of a contract with the CONTRACTOR. A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

21. Section A.2.12.17 shall be amended as follows:

2.12.17 All provider agreements for CLS and CLS-FM providers shall include a requirement that such providers allow DIDD staff access to pertinent CHOICES and ECF CHOICES member documentation as specified in TennCare protocol during 1915(c) waiver critical incident investigations in CLS and CLS-FM blended residences in instances where the critical incident may impact all residents of the home (for example, staff misconduct). For the purpose of this Contract, a CLS or CLS-FM blended residence is one in which at least one (1) CHOICES or ECF CHOICES member and one (1) 1915(c) waiver participant receive services in the same CLS or CLS-FM residence.

22. Section A.2.13.1.9 through A.2.13.1.9.6 shall be deleted and replaced as follows:

2.13.1.9 The CONTRACTOR agrees to implement retrospective episode based reimbursement and Primary Care Transformation strategies, inclusive of PCMH and Tennessee Health Link, consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE. This includes:

2.13.1.9.1 Using a retrospective administrative process to reward cost and quality outcomes for the initiative's payment reform strategies that is aligned with the models designed by TENNCARE.

2.13.1.9.2 Implementing key design choices as directed by TENNCARE, including the definition of each episode, and the definition of quality measures for the initiative's payment reform strategies.

2.13.1.9.3 Delivering performance reports for the initiative's payment reform strategies with the same appearance and content as those designed by the State/Payer Coalition.

2.13.1.9.4 Implementation of payment reform strategies at a pace dictated by the State. For episodes this is approximately three to six (3-6) new episodes per quarter with appropriate lead time to allow payer and provider contracting.

2.13.1.9.5 Implementation of aligned TennCare PCMH strategy shall include at least thirty-four percent (34%) of the CONTRACTOR's TennCare population beginning January 1, 2019 and at least thirty-five percent (35%) of the population beginning January 1, 2020.

2.13.1.9.5.1 TENNCARE shall monitor the CONTRACTOR's compliance in accordance with the following:

2.13.1.9.5.1.1 The CONTRACTOR shall submit separate PCMH membership counts for members attributed to groups that are anticipated to sign TennCare PCMH contracts as well as members attributed to groups who have executed TennCare PCMH contracts with the CONTRACTOR. PCMH membership counts shall be submitted in accordance with Section 2.30.10.9.

2.13.1.9.5.1.2 The percentage of compliance shall be calculated using the following formulas:

Target Date	Formula
July 31	CONTRACTOR's total TennCare PCMH membership as of June 30 from <i>anticipated</i> PCMH TINs for January 1 of following year / CONTRACTOR's total TennCare members with an assigned PCP, excluding non-aligned dual eligible members as of June 30

January 31	CONTRACTOR's total TennCare PCMH membership as of January 1 from <i>actual</i> PCMH TINs for January 1 of actual year / CONTRACTOR's total TennCare members with an assigned PCP, excluding non-aligned dual eligible members as of January 1
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2.13.1.9.5.1.3 TENNCARE shall monitor the CONTRACTOR's progress in accordance with the following timeline:

Target Date	Benchmark
July 31, 2018	TENNCARE shall verify that the CONTRACTOR is on track to meet the PCMH membership requirement for 2019
January 31, 2019	TENNCARE shall verify that the CONTRACTOR is meeting the PCMH membership requirement for 2019
July 31, 2019	TENNCARE shall verify that the CONTRACTOR is on track to meet the PCMH membership requirement for 2020 <u>AND</u> shall verify that the CONTRACTOR is still meeting the PCMH membership requirement for 2019
January 31, 2020	TENNCARE shall verify that the CONTRACTOR is meeting the PCMH membership requirement for 2020
July 31, 2020	TENNCARE shall verify that the CONTRACTOR is on track to meet the PCMH membership requirement for 2021 <u>AND</u> verifies shall verify that the CONTRACTOR is still meeting the PCMH membership requirement for 2020

2.13.1.9.5.1.4 Failure to meet and maintain the percentage benchmarks described above may result in liquidated damages described in Section E.29.

2.13.1.9.6 Participate in a State-led process to design and launch the initiative's payment reform strategies, including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee for the development of new episodes.

2.13.1.9.7 The CONTRACTOR shall submit an annual *Provider Engagement Plan* and quarterly *Provider Engagement Tracker* detailing information and communication plans with the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care providers in accordance with Sections A.2.30.10.6 and A.2.30.10.7.

23. Section A.2.13.3.3 shall be amended as follows:

2.13.3.3 If, prior to the end date specified by TENNCARE in its approval of Level II reimbursement for nursing facility services, the CONTRACTOR determines that the member no longer needs and/or the nursing facility is no longer providing the skilled and/or rehabilitative services for which Level II reimbursement of nursing facility services was approved by TENNCARE, the CONTRACTOR shall notify TENNCARE and, as appropriate, shall submit a request to modify the member's level of reimbursement for nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. Until the new nursing facility reimbursement methodology is effective in the TennCare Rules the CONTRACTOR may reimburse the nursing facility at the Level I (rather

than Level II) per diem rate only when such rate is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement or upon approval from TENNCARE of a reduction in the member's level of care (i.e., reimbursement) as reflected on the outbound 834 enrollment file.

24. Section A.2.14 shall be amended by deleting and replacing Sections A.2.14.1.14.1 and A.2.14.5.2 as follows:

2.14.1.14.1 Until the new nursing facility reimbursement methodology is effective in the TennCare Rules, the CONTRACTOR shall ensure that level II reimbursement of nursing facility care is provided for CHOICES members who have been determined by TENNCARE to be eligible for Level II reimbursement of nursing facility care for the period specified by TENNCARE, except when level I reimbursement is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement. The CONTRACTOR shall monitor the member's condition, and if the CONTRACTOR determines that, prior to the end date specified by TENNCARE, the member no longer requires and/or the facility is no longer providing the skilled and/or rehabilitative services for which Level II reimbursement of nursing facility care was approved by TENNCARE, the CONTRACTOR may submit to TENNCARE a request to modify the member's level of reimbursement for nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility at the Level I (rather than Level II) per diem rate only when such rate is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement or upon approval from TENNCARE of a reduction in the member's level of care (i.e., reimbursement) as reflected on the outbound 834 enrollment file.

2.14.5.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section A.2.14.1.14), except that, until the new nursing facility reimbursement methodology is effective in the TennCare Rules, the CONTRACTOR may reimburse a facility at the Level I per diem rate when such lesser rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement.

25. Section A.2.15.3.1.3 and A.2.15.5.5 shall be deleted and replaced as follows:

2.15.3.1.3 Based on the State's CMS-416 MCO report, if the CONTRACTOR has an overall rate below eighty percent (80%) the CONTRACTOR shall submit a PIP on EPSDT Screening and Community outreach plans in addition to the above required PIP's. The CONTRACTOR shall use existing processes, methodologies, and protocols, including the CMS protocols.

2.15.5.5 The CONTRACTOR shall assure the NCQA Accreditation Report is provided to TENNCARE for each accreditation cycle within ten (10) days of receipt of the report from NCQA. Updates of accreditation status, based on annual HEDIS scores must also be submitted within ten (10) days of receipt.

26. Section A.2.15.7.1 shall be amended by deleting and replacing Sections A.2.15.7.1.1, A.2.15.7.1.3, A.2.15.7.1.3.1 and A.2.15.7.1.5 as follows:

2.15.7.1.1 The CONTRACTOR shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term services and supports service delivery setting, including: community-based residential alternatives; adult day care centers; other CHOICES HCBS provider sites; and a member's home or any other community-based setting. Critical incidents shall include incidents that occur during the provision of covered CHOICES HCBS and incidents that are discovered or witnessed by the CONTRACTOR, provider, or FEA staff, regardless of whether the provider is believed to be responsible for the incident and/or other HCBS system factors are believed to have contributed to the incident.

2.15.7.1.3 Critical incidents shall include the following incidents when they occur in a home and community-based long-term care service delivery setting (as defined in Section A.2.15.7.1.1 above):

2.15.7.1.3.1 Any unexpected death of a CHOICES member;

2.15.7.1.5 In the manner required by TENNCARE, within one (1) business day of detection or notification, the CONTRACTOR must report to TENNCARE any unexpected death and any incident reported to APS. The timeframe for reporting to TENNCARE shall begin from the time of detection by a provider or upon receipt of information relative to the incident by CONTRACTOR staff, whichever is sooner.

27. Section A.2.15.7.3.3 shall be deleted in its entirety.

28. Section A.2.15.7.6 shall be amended by deleting and replacing Sections A.2.15.7.6.1 and A.2.15.7.6.3.1.7 as follows:

2.15.7.6.1 The CONTRACTOR shall develop and implement in coordination with DIDD a Reportable Event management system for Reportable Events involving ECF CHOICES members that occur in a home and community-based long-term service and supports delivery setting, if the Reportable Event occurs during the provision of covered ECF CHOICES services or is discovered or witnessed by the CONTRACTOR, provider, or FEA staff, regardless of whether the provider is believed to be responsible for the event and/or other HCBS system factors are believed to have contributed to the event.

2.15.7.6.3.1.7 Theft of more than \$1,000 (Class E felony).

29. Section A.2.17.3.1 shall be amended as follows:

2.17.3.1 The CONTRACTOR shall distribute member materials as required by this Contract. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters, identification cards, CHOICES member education materials, and ECF CHOICES member education materials.

30. Sections A.2.17.5 through A.2.17.5.4.2, A.2.17.8.3, A.2.17.8.5 and A.2.17.8.6 shall be deleted and replaced as follows:

A.2.17.5 Quarterly Member Newsletter

- 2.17.5.1 The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.
- 2.17.5.2 The CONTRACTOR shall include the following information in each newsletter:
 - 2.17.5.2.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;
 - 2.17.5.2.2 The procedure on how to obtain information in alternative communication formats, such as auxiliary aids or services and how to access language assistance services (i.e., interpretation and translation services) as well as a statement that interpretation and translation services and auxiliary aids or services are free. The notice of non-discrimination and taglines as required by TENNCARE shall be set forth in TENNCARE's tagline template;
 - 2.17.5.2.3 TennCare Kids information, including but not limited to, encouragement to obtain screenings and other preventive care services;
 - 2.17.5.2.4 One article on teen health written for enrollees between the ages of 12 and 20. Each quarter, the teen health article must fall into one of four required categories: medical/physical health, behavioral health, anticipatory guidance, and dental. Each category must be addressed once per calendar year;
 - 2.17.5.2.5 At least one specific article targeted to CHOICES members;
 - 2.17.5.2.6 At least one specific article targeted to ECF CHOICES members;
 - 2.17.5.2.7 Information about appropriate prescription drug usage;
 - 2.17.5.2.8 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and
 - 2.17.5.2.9 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to <http://tn.gov/tenncare> and click on 'Stop TennCare Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."
- 2.17.5.3 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly general newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. The newsletter may be distributed in alternative formats chosen by the CONTRACTOR and approved by TENNCARE. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, the following proof of distribution:

- 2.17.5.3.1 Submit a final copy, describe the method/media the CONTRACTOR used to disseminate the newsletter and documentation from the MCO's staff or outside vendor indicating the quantity and date disseminated as proof of compliance by the 30th of the month following each quarter.
- 2.17.8.3 The CONTRACTOR shall also be responsible for maintaining updated provider information in an online searchable electronic general provider directory and an online searchable electronic CHOICES and ECF CHOICES provider directory. A PDF copy of the hard copy version shall not meet this requirement. The online searchable version shall be available in a machine readable file and format in accordance with federal requirements. The online searchable version of the general provider directory and the CHOICES and ECF CHOICES provider directory shall be updated a minimum of three (3) days a week. In addition, the CONTRACTOR shall make available upon request, in hard copy format, a complete and updated general provider directory to all members and applicants and updated CHOICES or ECF CHOICES provider directory to CHOICES or ECF CHOICES members and applicants, as applicable. The hard copy of the general provider directory and the CHOICES and ECF CHOICES provider directory shall be updated at least on a monthly basis. Individuals receiving a hard copy and/or accessing a PDF version of the hard copy on the CONTRACTOR's website of the general provider directory or the CHOICES or ECF CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers, including the searchable electronic version of the general provider directory and the CHOICES or ECF CHOICES provider directory and the CONTRACTOR's member services line.
- 2.17.8.5 The CONTRACTOR shall develop and maintain a general provider directory, which shall be made available to all members and applicants. The provider directory shall be posted on the CONTRACTOR's website, and provided in hard copy upon request of the individual. Individuals shall be advised in writing regarding how to access the provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Individuals receiving a hard copy of the provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers. The online version of the provider directory shall be updated a minimum of three (3) days a week. The general provider directory shall include the following: names, locations, website, telephone numbers, office hours, and non-English languages spoken cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, whether the provider has completed cultural competence training; whether offices/facilities have accommodations for people with physical disabilities; including offices, exam room(s) and equipment; specialties as appropriate; identification of providers accepting new patients; and identification of whether or not a provider performs TennCare Kids screens; behavioral health providers; any group affiliations; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES/ECF CHOICES members should refer to the CHOICES/ECF CHOICES provider directory for information on long-term care providers and the weblink to those on-line directories.
- 2.17.8.6 The CONTRACTOR shall develop and maintain a CHOICES and ECF CHOICES provider directory that includes long-term care providers. The CHOICES and ECF CHOICES provider

directory, shall be made available to all CHOICES or ECF CHOICES members and applicants, as applicable, shall include the following: nursing facility listings with the name, location, and telephone number of each facility; community-based residential alternatives, by type, with the name, location, and telephone number of each facility; and a listing of other (non-residential) CHOICES and ECF CHOICES HCBS providers with the name, location, telephone number, and type of services by county of each provider. The CHOICES and ECF CHOICES provider directory shall be posted on the CONTRACTOR's website, and provided in hard copy upon request of the member. Members shall be advised in writing regarding how to access the CHOICES and ECF CHOICES provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the CHOICES or ECF CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers. The online version of the CHOICES and ECF CHOICES provider directory shall be updated a minimum of three (3) days a week.

31. Section A.2.18.6.3.18 shall be amended as follows:

2.18.6.3.18 The member grievance and appeal processes; and

32. Section A.2.19 shall be deleted and replaced as follows:

A.2.19 GRIEVANCES AND APPEALS

A.2.19.1 General

As permitted under federal and state law, the State, at its sole discretion, may delegate back to the State any portion of this Section A.2.19 that the CONTRACTOR is obligated to perform. The CONTRACTOR understands that the Grievance and Appeal process requirements are always subject to change based on legal developments and on TENNCARE's interpretation of its obligations under new or existing law. CMS has determined that the Reconsideration phase of TENNCARE's existing State Fair Hearing (SFH)/Appeal process satisfies the requirement for a CONTRACTOR-level benefit appeal process. Accordingly, enrollees will not be required to exhaust an appeal with the CONTRACTOR before requesting a SFH/Appeal. In this section A.2.19, the terms "appeal" and "state fair hearing" are synonymous—each refers to the *TennCare* appeal process, and to enrollee requests to engage the *TennCare* state fair hearing process.

2.19.1.1 Grievance System. Although CONTRACTOR shall follow *TENNCARE's* process for handling enrollee appeal requests, the CONTRACTOR shall have its own internal system for processing *grievances* filed with the CONTRACTOR. As distinguished from an "appeal", a "grievance" includes a complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The CONTRACTOR shall have a formally structured internal Grievance System in place for handling enrollee grievances in accordance with 42 CFR §438.402(a)-(b), and 42 CFR §438.228(a) and in accordance with the definition of "Grievance" found in section A.1. of this Contract.

- 2.19.1.2 TENNCARE Appeal System. TENNCARE, on written approval from CMS, has delegated back to itself certain aspects of the benefit appeal process set forth under 42 CFR 438 subpart F. Specifically, CONTRACTOR shall not have its own internal appeal system for enrollee benefit appeals. Enrollees will not exhaust an internal appeal process with CONTRACTOR before being permitted to request a TENNCARE appeal. Therefore, CONTRACTOR shall not operate its own internal appeal process. CONTRACTOR must fulfill its obligations as described in Contract Section A.2.19. CONTRACTOR shall not modify the appeal process except by written direction from TENNCARE. Accordingly, the provisions in 42 CFR § 438.402 that relate to a CONTRACTOR-level appeal system do not apply under this Contract. The enrollee will receive these protections through the Reconsideration phase of the TENNCARE appeal process. Any enrollee who seeks to contest an adverse benefit determination may do so by filing a request with TENNCARE for a TENNCARE appeal.
- 2.19.1.3 Reasonable Assistance with Grievances and Requests for Appeal. The CONTRACTOR must give enrollees any reasonable assistance in completing grievance and appeal forms and other procedural steps related to a grievance or appeal. This includes availability of enrollee support staff, auxiliary aids and services, such as interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. See 42 C.F.R. §438.406(a); 42 C.F.R. §438.228(a).
- 2.19.1.4 Acknowledgment of Grievances and Requests for Appeal.
- 2.19.1.4.1 Acknowledgment of Grievances. In accordance with 42 CFR §438.406(b) and 42 CFR §438.228(a), CONTRACTOR shall acknowledge receipt of an enrollee grievance.
- 2.19.1.4.2 Acknowledgment of Requests for SFH/Appeal. In accordance with 42 CFR §438.406(b) and 42 CFR §438.228(a), the CONTRACTOR shall acknowledge receipt of an enrollee grievance. If an enrollee attempts to contest an Adverse Benefit Determination by filing an appeal/SFH request with the CONTRACTOR, the CONTRACTOR shall submit the SFH request to TENNCARE within one (1) business day for expedited SFH requests and within five (5) business days for standard SFH requests. TENNCARE will send the enrollee an acknowledgement letter and inform the enrollee that the matter will be treated as a request for a SFH..
- 2.19.1.5 Decision-Makers. The CONTRACTOR shall ensure that decision-makers on grievances, and decision-makers responsible for rendering a medical review of CONTRACTOR's proposed adverse benefit determination during the Reconsideration stage of the appeal process, were not either:
- 2.19.1.5.1 Involved in any previous level of review or decision-making relating to the grievance or benefit appeal, or
- 2.19.1.5.2 Subordinates of any individual who was involved in a previous level of review or decision-making relating to the grievance or benefit appeal. See 42 C.F.R. §438.406(b)(2)(i); 42 C.F.R. §438.228(a).
- 2.19.1.6 Clinical Expertise of Decision-Maker. The CONTRACTOR shall require that decision-makers on grievances and decision-makers on any aspect of the appeal process (such as the Reconsideration decision) are individuals with appropriate clinical expertise, as determined by applicable law, in treating the enrollee's condition or disease if:
- 2.19.1.6.1 The decision hinges on whether a benefit request meets medical necessity,
- 2.19.1.6.2 The decision concerns whether to grant a request for expedited resolution of an appeal, or concerns a grievance about a previous denial of an expedited resolution request, or

- 2.19.1.6.3 The decision hinges on the decision-maker's assessment of clinical issues. See 42 C.F.R. §438.406(b)(2)(ii)(A) – (C); 42 C.F.R. §438.228(a).
- 2.19.1.7 Information to be considered. The CONTRACTOR's decision-makers shall take into account all comments, documents, records, and other information submitted during the grievance, prior authorization, or appeal process without regard to whether such information was submitted or considered in the initial adverse benefit determination. See 42 C.F.R. §438.406(b)(2)(iii); 42 C.F.R. §438.228(a).

A.2.19.2 **Notice of Adverse Benefit Determination (NABD) Requirements**

- 2.19.2.1 NABD Content. The CONTRACTOR'S NABD shall explain, in plain language, the adverse benefit determination the CONTRACTOR has made or intends to make. See 42 C.F.R. §438.404(b)(1).
- 2.19.2.2 NABD Content. The CONTRACTOR'S NABD shall explain the reasons for the adverse benefit determination, and shall explain the enrollee's right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. See 42 C.F.R. §438.404(b)(2).
- 2.19.2.3 NABD Content. The CONTRACTOR'S NABD must explain the enrollee's right to appeal the CONTRACTOR's adverse benefit determination by filing a request for an appeal with TENNCARE. See 42 C.F.R. §438.404(b)(3); 42 C.F.R. 438.402(b)-(c).
- 2.19.2.4 NABD Content. The CONTRACTOR'S NABD shall explain the procedures necessary for requesting an appeal. See 42 C.F.R. §438.404(b)(4).
- 2.19.2.5 NABD Content: How to request expedited resolution. The CONTRACTOR'S NABD must explain the circumstances under which the appeal can be expedited and how to request expedited resolution. See 42 C.F.R. §438.404(b)(5).
- 2.19.2.6 NABD Content: Requests for Continuation of Benefits (COB). The CONTRACTOR'S NABD shall explain the enrollee's right to have benefits continue until the appeal is resolved and must explain the procedures necessary for exercising this right. Additionally, if permitted by TennCare policy, the NABD shall explain the circumstances under which the enrollee may be required to pay the costs of continued services. See 42 C.F.R. §438.404(b)(6).
- 2.19.2.7 NABD Templates. In order to ensure consistency and to lessen the risk of issuing a notice that fails to meet applicable requirements, the CONTRACTOR shall use TENNCARE-developed or TENNCARE-approved NABD templates. NABD templates shall be written in a format and language that, at a minimum, meets applicable notification standards set forth at 42 CFR §438.10 and the notice-content requirements prescribed by 42 CFR §438.404(b).

A.2.19.3 **Notice of Adverse Benefit Determination Timing**

- 2.19.3.1 When the CONTRACTOR's adverse benefit determination is a termination, suspension, or reduction of previously authorized covered service, the CONTRACTOR shall mail the NABD at least ten (10) days before the date of action. See 42 C.F.R. §438.404(c)(1); 42 C.F.R. §431.211.

- 2.19.3.2 The CONTRACTOR may mail the NABD as few as five (5) days prior to the date of action if TENNCARE has facts indicating that action should be taken because of probable fraud by the enrollee, and the facts have been verified, if possible, through secondary sources. See 42 C.F.R. §438.404(c)(1); 42 C.F.R. §431.214.
- 2.19.3.3 The CONTRACTOR shall mail the NABD by the date of the action when any of the following occur:
 - 2.19.3.3.1 The enrollee has died,
 - 2.19.3.3.2 The enrollee submits a signed written statement requesting service termination,
 - 2.19.3.3.3 The enrollee submits a signed written statement including information that requires service termination or reduction and indicates an understanding that service termination or reduction will result,
 - 2.19.3.3.4 The enrollee has been admitted to an institution where he or she is ineligible under the plan for further services,
 - 2.19.3.3.5 The enrollee's address is determined unknown based on returned mail with no forwarding address,
 - 2.19.3.3.6 The enrollee is accepted for Medicaid services by another state,
 - 2.19.3.3.7 A change in the level of medical care is prescribed by the enrollee's physician,
 - 2.19.3.3.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act, or
 - 2.19.3.3.9 The transfer or discharge from a facility shall occur in an expedited fashion. See 42 C.F.R. §438.404(c)(1); 42 C.F.R. §431.213; 42 C.F.R. §431.231(d); section 1919(e)(7) of the Act; 42 C.F.R. 483.12(a)(5)(i); 42 C.F.R. §483.12(a)(5)(ii).
- 2.19.3.4 The CONTRACTOR shall give NABD on the date of determination when the action is a denial of payment. See 42 C.F.R. §438.404(c)(2).
- 2.19.3.5 The CONTRACTOR shall give NABD as expeditiously as the enrollee's condition requires within fourteen (14) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services. See 42 C.F.R. §438.210(d)(1); 42 C.F.R. §438.404(c)(3).
- 2.19.3.6 The CONTRACTOR may extend the fourteen (14) calendar day NABD timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional calendar days if the enrollee or the provider requests extension. See 42 C.F.R. §438.404(c)(4); 42 C.F.R. §438.210(d)(1)(i).
- 2.19.3.7 The CONTRACTOR may extend the fourteen (14) calendar day NABD timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional calendar days if the CONTRACTOR justifies to TENNCARE a need for additional information and shows how the extension is in the enrollee's best interest. See 42 C.F.R. §438.210(d)(1)(ii); 42 C.F.R. §438.404(c)(4).

- 2.19.3.8 If the CONTRACTOR extends the fourteen (14) calendar day NABD timeframe for standard authorization decisions that deny or limit services, the CONTRACTOR shall give the extension and inform the enrollee of the right to file a grievance with CONTRACTOR if the enrollee disagrees with the decision. See 42 C.F.R. §438.210(d)(1)(ii); 42 C.F.R. §438.404(c)(4)(i).
- 2.19.3.9 If the CONTRACTOR extends the fourteen (14) calendar day NABD timeframe for standard authorization decisions that deny or limit services, the CONTRACTOR shall issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. See 42 C.F.R. §438.210(d)(1)(ii); 42 C.F.R. §438.404(c)(4)(ii).
- 2.19.3.10 If the CONTRACTOR determines that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. See 42 C.F.R. §438.210(d)(2)(i); 42 C.F.R. §438.404(c)(6).
- 2.19.3.11 The CONTRACTOR may extend the seventy-two (72) hour expedited service authorization decision time period by up to fourteen (14) calendar days if the enrollee requests an extension, or if the CONTRACTOR justifies to TENNCARE the need for additional information and how the extension is in the enrollee's interest. See 42 C.F.R. §438.210(d)(2)(ii); 42 C.F.R. §438.404(c)(6).

A.2.19.4 **Who May File Appeals**

- 2.19.4.1 Enrollees shall be instructed to file appeal requests with TENNCARE. If an enrollee attempts to contest an adverse benefit determination by filing an appeal request with CONTRACTOR (instead of with TENNCARE as instructed), CONTRACTOR shall, in accordance with 42 C.F.R. §438.406, assist the enrollee to ensure the prospective appeal is filed with TENNCARE. TENNCARE will send enrollee an acknowledgement letter and inform enrollee that the request has been received. See 42 C.F.R. §438.402(c)(1); 42 C.F.R. §438.406; and §438.408.
- 2.19.4.2 Enrollee-authorized representatives, acting on behalf of the enrollee and with the enrollee's written consent, may file appeal requests and may represent the enrollee during the appeal. The enrollee's treating provider may serve as an authorized representative, but may not request provision of continuation of benefits. See 42 C.F.R. §438.402(c)(1)(i) – (ii); 42 C.F.R. §438.408. See also definition of “Enrollee-Authorized Representative” herein at §A.1.

A.2.19.5 **Timeframes for Filing Requests for Appeal**

- 2.19.5.1 Enrollee must file an appeal request within sixty (60) calendar days from the date on the CONTRACTOR-issued NABD. It is TENNCARE's responsibility to determine whether or not the appeal request is timely. See 42 CFR 438.402(c)(2)(ii).

A.2.19.6 **Process for Filing a Standard or Expedited Request for Appeal**

- 2.19.6.1 Enrollee may file a request for appeal either orally or in writing. See 42 C.F.R. §438.402(c)(3)(ii).
- 2.19.6.2 ORR for Expedited Resolution Determination. When an enrollee files a request for expedited resolution of an appeal, TENNCARE will issue an On Request Report (ORR) to CONTRACTOR. The ORR requires CONTRACTOR to determine whether the request warrants expedited or standard resolution. If CONTRACTOR determines that the request warrants expedited resolution, within seventy-two (72) hours of the time that the expedited resolution request was filed, CONTRACTOR shall simultaneously supply TENNCARE with both its (1)

resolution timeframe decision, and its (2) reconsideration determination. If CONTRACTOR determines that the appeal request warrants standard resolution, CONTRACTOR shall supply its resolution timeframe decision to TENNCARE within two (2) business days, and shall supply TENNCARE its reconsideration determination within the timeframe provided in Section A.2.19.6.2.1.

- 2.19.6.2.1 ORR for Reconsideration. If the enrollee's appeal request warrants expedited resolution, as provided in 2.19.6.2, the CONTRACTOR shall simultaneously supply TENNCARE with both its resolution timeframe decision and its reconsideration determination. If the CONTRACTOR determines that the appeal request warrants standard resolution, CONTRACTOR shall complete its Reconsideration review and submit its Reconsideration decision to TENNCARE, along with the other information requested in the ORR, within fourteen (14) days of the time that the appeal request was filed. If the CONTRACTOR denies a request for expedited resolution, the matter shall receive standard resolution. See 42 C.F.R. §438.410(c); 42 C.F.R. §438.408(b)(2); 42 C.F.R. §438.408(c)(2).
- 2.19.6.2.2 Test for whether Appeal warrants Standard or Expedited Resolution. A benefit under dispute warrants expedited resolution if the CONTRACTOR determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Although the enrollee or his treating provider may request expedited resolution, the CONTRACTOR alone has the authority to determine whether an enrollee appeal receives expedited or standard resolution. See 42 C.F.R. §438.410(a); Final Rule, 81 Fed. Reg. 27,498, 27,519 (May 6, 2016) (to be codified at 42 C.F.R. pt. 438).
- 2.19.6.2.3 Information to be supplied in response to ORR for Reconsideration. CONTRACTOR's Reconsideration response shall contain all of the information used by CONTRACTOR in arriving at the adverse benefit determination. This includes the enrollee medical records and any other information considered, relied upon, or created in arriving at a Prior Authorization or Reconsideration decision. (TENNCARE will provide this information to enrollee when TENNCARE issues its Notice of Hearing to enrollee. See §2.19.6.4 below.) For example, CONTRACTOR's Reconsideration response must include the following:
- 2.19.6.2.3.1 Complete case file;
- 2.19.6.2.3.2 Medical records and medical history pertaining to the benefit under dispute;
- 2.19.6.2.3.3 NABD issued to enrollee by CONTRACTOR;
- 2.19.6.2.3.4 Prior authorization decision issued to requesting provider by CONTRACTOR;
- 2.19.6.2.3.5 Medical review substantiating the prior authorization decision; and
- 2.19.6.2.3.6 CONTRACTOR's Reconsideration decision upholding or reversing original prior authorization determination, along with the attendant substantiating medical review. See 42 C.F.R. §438.406(b)(5).
- 2.19.6.3 Parties at the Appeal's State Fair Hearing. The parties to a State Fair Hearing are TENNCARE and the enrollee (including enrollee's authorized representative, or the legal representative of a deceased enrollee's estate). See 42 C.F.R. §438.406(b)(6).

- 2.19.6.4 TennCare Notice of Hearing. TENNCARE will provide enrollee a Notice of Hearing, which informs enrollee of the hearing procedure and which contains the enrollee case file and includes the information used by the CONTRACTOR in arriving at its adverse benefit determination. TENNCARE will issue the Notice of Hearing sufficiently in advance of the requisite resolution timeframe. See 42 C.F.R. §438.406(b)(4); 42 C.F.R. §438.408(b); 42 C.F.R. §438.408(c).
- 2.19.6.5 The CONTRACTOR shall ensure that punitive action is not taken against a provider who requests expedited resolution, or who supports an enrollee's request for appeal. See 42 C.F.R. §438.410(b).

A.2.19.7 Timeframes for Resolving Standard and Expedited Appeal Requests

- 2.19.7.1 Each appeal shall be resolved as expeditiously as the enrollee's health condition requires. Standard appeals shall be resolved within ninety (90) calendar days of receipt; Expedited appeals shall be resolved within three business days of TENNCARE's receipt of CONTRACTOR's Reconsideration response. CONTRACTOR's Reconsideration response must be received within 72 hours of enrollee's request for appeal. See 42 C.F.R. §438.408(a); 42 C.F.R. §438.408(b)(2)-(3); 42 C.F.R. §431.244(f)(2).
- 2.19.7.2 The CONTRACTOR may extend the resolution timeframe by up to fourteen (14) calendar days if either:
 - 2.19.7.2.1 The enrollee requests the extension, or
 - 2.19.7.2.2 Consistent with TennCare policy, the CONTRACTOR shows the need for additional information and shows that the delay is in the enrollee's interest. See 42 C.F.R. §438.408(c)(1); 42 C.F.R. §438.408(b)(2).
- 2.19.7.3 If the CONTRACTOR extends the resolution timeframe pursuant to A.2.19.7.2, CONTRACTOR shall, within two (2) calendar days, give enrollee written notice of the reason for the extension. (Reasonable effort should also be made to confer oral notice). This written notice shall inform enrollee of the right to file a grievance with CONTRACTOR if enrollee disagrees with the extension. See 42 C.F.R. §438.408(c)(2)(i)-(iii); 42 C.F.R. §438.408(b)(2).

A.2.19.8 Notice of Appeal Resolution

- 2.19.8.1 TENNCARE must provide enrollee with a written and dated notice of appeal resolution. The notice of appeal resolution must be in a format and language that meets 42 C.F.R. §438.10.
- 2.19.8.2 If the notice of resolution concerns an expedited appeal, in addition to the written notice supplied to enrollee by TENNCARE, the CONTRACTOR shall make reasonable effort to confer oral notice of the expedited appeal resolution, and shall document its efforts to do so. See 42 C.F.R. §438.408(d)(2)(ii).

A.2.19.9 Continuation of Benefits

- 2.19.9.1 The CONTRACTOR shall not accept a continuation of benefits request from a provider, since providers are prohibited from requesting continuation of benefits pursuant to 42 C.F.R. §438.402(c)(1)(ii) and §438.420(b)(5). The CONTRACTOR shall continue the enrollee's benefits while an appeal is in process if all of the following occur:
 - 2.19.9.1.1 The enrollee files the request for an appeal within sixty (60) calendar days following the date on the NABD.

- 2.19.9.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized Medicaid service.
- 2.19.9.1.3 The enrollee's services were ordered by an authorized provider.
- 2.19.9.1.4 The period covered by the original authorization has not expired.
- 2.19.9.1.5 Enrollee files the request for continuation of benefits within ten (10) calendar days of the date on the NABD, or if enrollee files the request before the intended effective date of the proposed adverse benefit determination. See; 42 C.F.R. §438.420(b)(1)-(5); 42 C.F.R. §438.402(c)(2)(ii).
- 2.19.9.2 If, at the enrollee's request, the CONTRACTOR continues or reinstates the enrollee's benefits while the appeal is pending, the benefits shall be continued until one of the following occurs:
 - 2.19.9.2.1 The enrollee withdraws the appeal; or
 - 2.19.9.2.2 An appeal decision adverse to the enrollee is issued. See 42 C.F.R. §438.420(c)(1)-(3); 42 C.F.R. §438.408(d)(2).
- 2.19.9.3 The CONTRACTOR shall authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires (but no later than seventy-two (72) hours from the date it receives notice reversing the determination). See 42 C.F.R. §438.424(a). The CONTRACTOR's initial adverse determination can be reversed in one of three ways during the appeal process: (1) By the CONTRACTOR itself (during Reconsideration), (2) By TENNCARE following its pre-hearing medical necessity or coverage review, or (3) by the hearing officer's Initial Order resolving the appeal. In each of the three situations, TENNCARE will issue a directive instructing CONTRACTOR of the action it shall take and of the attendant deadline.
- 2.19.9.4 The CONTRACTOR shall pay for disputed services received by the enrollee while the appeal was pending in the event that the CONTRACTOR's Reconsideration determination or the TENNCARE appeal resolution reverses the CONTRACTOR's initial decision to deny authorization of the benefit under appeal. See 42 C.F.R. §438.424(b).
- 2.19.9.5 The CONTRACTOR shall notify the requesting provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. See 42 C.F.R. §438.210(c); 42 C.F.R. §438.404.

A.2.19.10 Grievances

- 2.19.10.1 The CONTRACTOR shall allow an enrollee to file an oral or written grievance with a CONTRACTOR at any time. See 42 C.F.R.438.402(c)(2)(i); 42 C.F.R.438.402(c)(3)(i).
- 2.19.10.2 The CONTRACTOR shall resolve each grievance and provide notice of grievance resolution within ninety (90) calendar days from the day the CONTRACTOR receives the grievance. See 42 C.F.R. §438.408(a); 42 C.F.R. §438.408(b)(1).
- 2.19.10.3 The CONTRACTOR shall issue a written acknowledgment of receipt of the grievance within five (5) business days. This written acknowledgement need not be conferred if the CONTRACTOR issues the notice of grievance resolution within five (5) business days of receiving the grievance.

2.19.10.4 The CONTRACTOR shall issue a written, dated notice of grievance resolution in a format and language that meets 42 C.F.R. §438.10. See 42 C.F.R. §438.408(d)(1).

A.2.19.11 Grievance and Appeal Recordkeeping Requirements

2.19.11.1 The CONTRACTOR must maintain records of grievances and appeals and shall make such records readily available to TENNCARE or to CMS upon request. See 42 C.F.R. §438.416(a); 42 C.F.R. §438.416(c).

2.19.11.2 The CONTRACTOR's record of each grievance and appeal shall include:

2.19.11.2.1 A general description of the reason for the appeal or grievance.

2.19.11.2.2 The date received.

2.19.11.2.3 The date of each review or, if applicable, review meeting.

2.19.11.2.4 The date of resolution and how it was resolved.

2.19.11.2.5 The identity of the enrollee for whom the appeal or grievance was filed. See 42 C.F.R. §438.416(b)(1)-(6).

A.2.19.12 Provision of Information About Enrollee Grievance and Appeal Rights

2.19.12.1 The CONTRACTOR shall inform its assigned enrollees, contracted providers and subcontractors about the appeal process and shall inform them of the toll-free number for filing oral grievances and appeals. See 42 C.F.R. §438.414; 42 C.F.R. §438.10(g)(1)(v).

2.19.12.2 The CONTRACTOR shall include information about the enrollee's grievance and appeal rights in the following materials:

2.19.12.2.1 NABD and notice of appeal resolution;

2.19.12.2.2 Provider and subcontractor contracts with CONTRACTOR;

2.19.12.2.3 Member Handbook and Provider Manual;

2.19.12.2.4 Provider training materials;

2.19.12.2.5 CONTRACTOR website.

2.19.13 The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section A.2.15.2, to the review of enrollee appeals and to addressing identified deficiencies with the CONTRACTOR's grievance process or with CONTRACTOR's role in the TENNCARE appeal process.

2.19.14 The CONTRACTOR shall have a designated business unit responsible for processing grievances and appeals in accordance with applicable law and TENNCARE requirements. CONTRACTOR's appeals unit shall include sufficient numbers of appropriately trained and licensed physicians, clinicians, and support staff necessary to timely process appeals in accordance with potentially evolving regulatory and TENNCARE requirements.

- 2.19.15 At any point in the appeal process, TENNCARE must have the authority to remove an enrollee from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the enrollee and TENNCARE.
- 2.19.16 The CONTRACTOR understands that the grievance and appeal process requirements are always subject to change based on legal developments and on TENNCARE's interpretation of its obligations under new or existing law.
- 2.19.17 The CONTRACTOR shall provide general and targeted education to its contracted providers regarding the appeal process. This training shall cover the provider's rights and obligations concerning the appeal process including provider's obligation to timely supply medical records necessary for the appeal process and including requirements concerning submission of requests for expedited prior authorization decisions and requests for expedited appeal resolution.
- 2.19.18 The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described herein.
- 2.19.19 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- 2.19.20 Enrollee TennCare eligibility and eligibility-related grievances and appeals, including but not limited to, long-term care eligibility and enrollment, termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to TENNCARE.

33. Section A.2.20.1 shall be deleted and replaced as follows:

A.2.20 General

- 2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program.
- 2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.
- 2.20.1.3 The CONTRACTOR, and any subcontractors delegated responsibility for coverage of services or payment of claims under this Contract, shall implement and maintain a compliance program, as described 42 CFR 438.608, that includes, at a minimum:
 - 2.20.1.3.1 Written policies, procedures, and standards of conduct that demonstrate compliance with all applicable requirements and standards under the Contract, as well as all Federal and state requirements, related to program integrity.
 - 2.20.1.3.2 A designated Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. The Compliance Officer shall report to the CEO and the Board of Directors.
 - 2.20.1.3.3 A Regulatory Compliance Committee, consisting of members of the Board of Directors, which is responsible for oversight of the CONTRACTOR's compliance program.

- 2.20.1.3.4 A system for training and education for the Compliance Officer, directors, managers, and employees regarding the CONTRACTOR's compliance program and program integrity-related requirements.
- 2.20.1.3.5 Effective lines of communication between the CONTRACTOR's Compliance Officer and employees.
- 2.20.1.3.6 Enforcement of compliance program standards and program integrity-related requirements through well-publicized disciplinary guidelines.
- 2.20.1.3.7 A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems, and ongoing compliance with program integrity-related requirements.
- 2.20.1.4 The CONTRACTOR shall establish written policies and procedures for its employees, subcontractors, providers, and agents that provide detailed information about the False Claims Act and any other federal and state laws, including whistleblower protections, administrative remedies for false claims, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs. The CONTRACTOR shall include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.
- 2.20.1.5 The CONTRACTOR shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.
- 2.20.1.6 The CONTRACTOR, as well as its subcontractors shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request.
- 2.20.1.7 The CONTRACTOR's providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request. For providers, this requirement may be satisfied through TENNCARE's provider registration process.

- 2.20.1.8 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. The CONTRACTOR, its subcontractors and all tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall screen their owners and employees against the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). In addition, the CONTRACTOR and its subcontractors shall screen their owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the CONTRACTOR dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.
- 2.20.1.9 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.
- 2.20.1.10 The CONTRACTOR may recoup and retain overpayments made to providers within timeframes determined by the state.
- 2.20.1.10.1 The CONTRACTOR shall notify TennCare OPI of any non-administrative overpayments identified outside of the timeframes determined by the state, or for which recovery is prohibited under Section A.2.20.1.10. The CONTRACTOR shall take no actions to recoup the overpayments without written authorization from TennCare OPI.
- 2.20.1.10.2 The CONTRACTOR shall report to TennCare OPI all non-administrative overpayments, both identified and recovered, on a quarterly basis.
- 2.20.1.11 The CONTRACTOR is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
- 2.20.1.11.1 The improperly paid funds have already been recovered by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or
- 2.20.1.11.2 When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Tennessee or are the subject of pending Federal or State litigation or investigation,
- 2.20.1.11.3 The prohibition described in this section shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims.
- 2.20.1.11.4 The CONTRACTOR shall determine if the prohibition to recoup or withhold improperly paid funds is applicable utilizing methods as directed by TennCare OPI.
- 2.20.1.11.5 In the event that CONTRACTOR recoups or otherwise obtains funds in cases where overpayment recovery is prohibited, under this section or as otherwise directed by TennCare, the CONTRACTOR shall notify the Director of TennCare OPI and take action in accordance with written instructions from the Director of TennCare OPI.

2.20.1.11.6 If the CONTRACTOR fails to adhere to the prohibitions and requirements of this section, the CONTRACTOR may be subject to forfeiture of the funds to the State and the imposition of liquidated damages as described in Section E.29.2.

2.20.1.12 The CONTRACTOR shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

34. Section A.2.20.2.17 shall be amended by deleting the reference to Section A.2.12.9.42 and replacing it with the reference to Section A.2.12.9.36 as follows:

2.20.2.17 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall promptly report overpayments made by TENNCARE to the CONTRACTOR as well as overpayments made by the CONTRACTOR to a provider and/or subcontractor (See Section A.2.12.9.36).

35. Section A.2.29 shall be amended by deleting and replacing Sections A.29.1.2 and A.29.1.8 as follows:

2.29.1.2 The CONTRACTOR shall submit to TENNCARE the names, resumes and contact information of the key staff identified below. The CONTRACTOR shall supply information regarding work experience for any employee upon request. The CONTRACTOR shall not employ any person in a key staff position that does not meet the requirements specified in the Contract for the position without prior written approval from TENNCARE. If a key staff position is specified in the Contract as “dedicated” to particular programs or functions, the CONTRACTOR shall not assign such key staff person to perform other responsibilities without prior written approval from TENNCARE. In the event of a change to any of the key staff identified in Section A.2.29.1.3, the CONTRACTOR shall notify TENNCARE within ten (10) business days of the change. TENNCARE may request the replacement of any CONTRACTOR staff that TENNCARE determines, at its sole discretion, is adversely affecting the CONTRACTOR’s ability to meet the requirements of this Contract or is adversely affecting the CONTRACTOR’s relationship with the State.

2.29.1.8 The CONTRACTOR is not required to report to TENNCARE the names of staff not identified as key staff in Section A.2.29.1.3, unless requested by TennCare. However, the CONTRACTOR shall provide its staffing plan to TENNCARE.

36. Section A.2.30.4.5 shall be deleted and replaced as follows:

2.30.4.5 The CONTRACTOR shall submit Semi-Annual, a *Tennessee Health Link (THL) Engagement Evaluation Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TennCare on March 1 and September 1 of each year.

37. Section A.2.30.6.4 shall be amended by deleting Sections A.2.30.6.4.1, A.2.30.6.4.1.1, A.2.30.6.4.1.2, and A.2.30.6.4.1.3.

38. Section A.2.30.6.14 shall be amended as follows:

2.30.6.14 The CONTRACTOR shall submit a Housing Profile Assessment Report quarterly in a format specified by TENNCARE. This report shall monitor the housing needs of CHOICES and ECF CHOICES enrollees waiting to transition or post-transition and includes, but is not limited to, transition wait times, transition barriers, monthly income amounts, housing options chosen, and counties chosen for transition. Additionally, this report shall contain a listing of members receiving a housing supplement including but not limited to, 202 funds, CDBG funds, funds for assistive technology as it relates to housing, funds for home modifications, HOME dollars, housing choice vouchers (such as tenant based, project based, mainstream, or homeownership vouchers), housing trust funds, low income housing tax credits, section 811, USDA rural housing funds, Veterans Affairs housing funds, or other. This report shall contain the names, addresses, and monthly incomes of all the CONTRACTOR's members participating in the (MFP) Non-Profit Affordable Housing Development Grant Initiative. This report shall also contain a list of all members living in homes that are Medicaid-funded and built by Neighborworks America , and shall include the following minimum data elements: (1) member name; (2) member address; (3) member CHOICES or ECF CHOICES Group number; (4) whether member participates in MFP; (5) date member moved into the Neighborworks America residence; and (6) date member moved out of the Neighborworks America residence (left blank if still currently residing at that location).

39. Sections A.2.30.10.6 through A.2.30.10.7.3 shall be deleted and replaced and a new Section A.2.30.10.9 shall be added as follows:

2.30.10.6 The CONTRACTOR shall submit a single annual *Provider Engagement Plan* detailing communication plans with the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care providers no later than December 1st of each year for review and approval by TENNCARE. The *Provider Engagement Plan* shall be effective as of January 1st of the next calendar year.

2.30.10.6.1 The *Provider Engagement Plan* shall be written in accordance with guidance prepared by TENNCARE. This outreach plan shall outline communication efforts with providers engaged in the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care initiatives. It shall include, but is not limited to: all proposed education regarding reading and interpreting provider reports; all proposed details regarding report delivery and accessibility; a plan for (at least) quarterly in-person leadership meetings between MCO program leads and PCMH/THL practice leadership; detailed strategy outlining the providers or quarterbacks to prioritize when conducting outreach efforts (i.e. providers who did not open reports or owe a penalty).

2.30.10.6.2 For THL and PCMH providers with less than 500 members, the CONTRACTOR may alter the quarterly in person meeting schedule and/or meet by phone. For PCMH providers who have participated in the initiative for at least one year, the CONTRACTOR may alter the quarterly in person meeting schedule and/or meet by phone.

2.30.10.7 The CONTRACTOR shall submit a quarterly *Provider Engagement Tracker* in accordance with guidance prepared by TENNCARE. The CONTRACTOR shall submit the *Provider Engagement Tracker* no later than one (1) week after each quarter in the calendar year for the Tennessee Health Link (THL), Patient Centered Medical Homes (PCMH) and Episodes of Care initiatives. There should be separate quarterly *Provider Engagement Tracker* for THL, PCMH and Episodes of Care that shall record all in-person visits, calls, mailings, and all other communications for THL, PCMH and Episodes of Care. Therefore, each quarter, a total of three (3) separate *Provider*

Engagement Tracker shall be sent to TENNCARE by the CONTRACTOR. The details regarding when such outreach shall occur are described in Sections A.2.30.10.7.1 to A.2.30.10.7.3.

2.30.10.7.1 The CONTRACTOR shall alert all providers or quarterbacks to the availability of their reports through emails and/or letters. The CONTRACTOR shall supplement alerts to providers or quarterbacks with calls, in-person visit, WebEx, fax, provider Information Expos, State Medical Association Conferences, or online videos.

2.30.10.7.2 In the initial communication to providers or quarterbacks, the CONTRACTOR shall provide instructions on 1) how to access full reports, and 2) how to share or update electronic contact information. Ensuring that providers have given their most up-to-date contact information is essential for them to receive alerts about any changes to their reports or newly released reports.

2.30.10.7.3 The CONTRACTOR shall also use in-person education, newsletters, web banners, and scripted calls to share general information and updates about Episode of Care, Patient Centered Medical Home and Health Link reports.

2.30.10.9 The CONTRACTOR shall submit annual PCMH Membership Reports as follows:

2.30.10.9.1 The CONTRACTOR shall submit an annual *PCMH Membership/Anticipated PCMH Contract Report*. The report shall include PCMH membership counts as of June 30 of each year for members attributed to groups that are anticipated to sign TennCare PCMH contracts effective January 1 of the following year. PCMH membership shall exclude non-aligned dual eligible members. This PCMH Membership/Anticipated PCMH Contract Report is due to TENNCARE no later than July 31 of each year.

2.30.10.9.2 The CONTRACTOR shall submit an annual *PCMH Membership/Contracted PCMH Report*. The report shall include PCMH membership counts as of January 1 of each year for all members with an attributed PCP that is associated with a TIN contracted in the TennCare PCMH program. PCMH membership shall exclude non-aligned dual eligible members. This PCMH Membership/Contracted PCMH Report is due to TENNCARE no later than January 31 of each year.

40. Sections A.2.30.12.1 through A.2.30.12.1.5 and Section A.2.30.12.12 through A.2.30.12.12.1.5 shall be deleted in their entirety and the remaining Sections shall be renumbered accordingly, including any references thereto.

41. **Section B.1 shall be amended by replacing the reference to December 31, 2018 with December 31, 2019.**

B.1 This Contract shall be effective for the period beginning January 1, 2014, and ending on December 31, 2019. The Middle Tennessee region is scheduled to have implementation of services effective January 1, 2015. Implementation dates for West and East Tennessee will be determined by the State and shared with the contractors within one month of announcement of the winning proposers. In no case will these implementation dates be earlier than January 1, 2015 or later than January 1, 2016.

42. Section C.1.1 shall be deleted and replaced as follows:

C.1.1 In no event shall the maximum liability of the State under this Contract exceed Nine Billion, Eight Hundred Fifteen Million, Four Hundred Twenty Three Thousand, Six Hundred Fifty Dollars (\$9,815,423,650.00). The payment methodology in section C.3 shall constitute the entire compensation due the CONTRACTOR for all service and CONTRACTOR obligations hereunder regardless of the difficulty, materials or equipment required. The payment method or rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the CONTRACTOR.

43. Section E.29.2.2.7 shall be amended by correcting numbering typos created by Amendment 7 which renumbers Levels A.19(b) as A.20(b), A.36 as A.37 and A.41 as A.42 as well as adding new Levels A.16(d), A.16(e), and C.9 and amending Level A.21as follows:

LEVEL	PROGRAM ISSUES	DAMAGE
A.16(d)	Enrollee Benefit Appeals. Failure to submit an expedited appeal/SFH request to TENNCARE within one (1) business day.	\$500 per calendar day CONTRACTOR is in default
A.16(e)	Enrollee Benefit Appeals. Failure to submit a standard appeal/SFH request to TENNCARE within five (5) business days.	\$500 per calendar day CONTRACTOR is in default

LEVEL	PROGRAM ISSUES	DAMAGE
A.20(b)	Failure to follow and complete the Employment Informed Choice process for ECF CHOICES members (see Section A.2.9.6.2 and A.2.9.6.3)	\$500 per member per day for each day that the Employment Informed Choice process is not completed as specified in this Contract and pursuant to TennCare protocol. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract

A.21	Failure to develop a PCSP for a CHOICES or ECF CHOICES member that includes all of the required elements, and which has been reviewed with and signed and dated by the member or his/her representative, unless the member/representative refuses to sign which shall be documented in writing	\$500 per deficient PCSP These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
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A.37	Failure to complete the PAE process and/or ensure that a PAE is submitted to TENNCARE within twenty (20) business days of the enrollment visit, per Section A.2.9.6.14, on all referrals, except those individuals who are screened out who do not subsequently request to continue the intake process or individuals who choose to terminate the intake process, which must be documented in writing	\$500 per day beginning twenty (20) business days after completion of the enrollment visit until date of PAE submission
A.42	Failure to complete transition planning, implementation, and monitoring requirements set forth in Section A.2.9.6.9 for a CHOICES or ECF CHOICES member transitioning to a new CBRA setting	\$5,000 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
C.9	Failure to achieve benchmarks of 34%/35% PCMH membership (see Section A.2.13.1.9.5)	\$500 per calendar day, per individual benchmark, for each day the CONTRACTOR fails to achieve and/or maintain each benchmark

44. Section E.39 shall be deleted and replaced as follows:

E.39 SOCIAL SECURITY ADMINISTRATION (SSA) REQUIRED PROVISIONS FOR DATA SECURITY

The CONTRACTOR shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. §552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the CONTRACTOR shall have in place administrative, physical, and technical safeguards for data.

E.39.1 The CONTRACTOR shall not duplicate in a separate file or disseminate, without prior written permission from TENNCARE, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the CONTRACTOR propose a redisclosure of said data, the CONTRACTOR must specify in writing to TENNCARE the data the CONTRACTOR proposes to redisclose, to whom, and the reasons that justify the redisclosure. TENNCARE will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

E.39.2 The CONTRACTOR agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

- E.39.3 The CONTRACTOR shall maintain a current list of the employees of such CONTRACTOR with access to SSA data and provide such lists to TENNCARE upon request and at any time there are changes.
- E.39.4 The CONTRACTOR shall restrict access to the data obtained from TENNCARE to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The CONTRACTOR shall not further duplicate, disseminate, or disclose such data without obtaining TENNCARE's prior written approval.
- E.39.5 The CONTRACTOR shall ensure that its employees:
 - E.39.5.1 Properly safeguard SSA data furnished by TENNCARE under this Contract from loss, theft or inadvertent disclosure;
 - E.39.5.2 Receive regular, relevant and sufficient SSA data related training, including use, access and disclosure safeguards and information regarding penalties for misuse of information;
 - E.39.5.3 Understand and acknowledge that they are responsible for safeguarding this information at all times, regardless of whether or not the CONTRACTOR employee is at his or her regular duty station;
 - E.39.5.4 Ensure that laptops and other electronic devices/ media containing SSA data are encrypted and/or password protected;
 - E.39.5.5 Send emails containing SSA data only if the information is encrypted or if the transmittal is secure; and
 - E.39.5.6 Limit disclosure of the information and details relating to a SSA data loss only to those with a need to know.

CONTRACTOR employees who access, use, or disclose TennCare SSA-supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.
- E.39.6 Loss or Suspected Loss of Data – If an employee of the Contractor becomes aware of suspected or actual loss of SSA data, the Contractor must notify TennCare immediately upon becoming aware to report the actual or suspected loss. The Contractor must provide TennCare with timely updates as any additional information about the loss of SSA data becomes available.
 - E.39.6.1 If the CONTRACTOR experiences a loss or breach of said data, TENNCARE will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the CONTRACTOR shall bear any costs associated with the notice or any mitigation.
- E.39.7 TENNCARE may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TENNCARE, in its sole discretion, determines that the CONTRACTOR has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract Section.
- E.39.8 Legal Authority
 - E.39.8.1 Federal laws and regulations giving SSA the authority to disclose data to TENNCARE and TENNCARE's authority to collect, maintain, use and share data with CONTRACTOR is protected under federal law for specified purposes:

- 39.8.1.1 Sections 1137, 453, and 1106(b) of the Social Security Act (the Act) (42 U.S.C. §§ 1320b-7, 653, and 1306(b)) (income and eligibility verification data);
 - 39.8.1.2 26 U.S.C. § 6103(1)(7) and (8) (tax return. data);
 - 39.8.1.3 Section 202(x)(3)(B)(iv) of the Act (42 U.S.C. § 401(x)(3)(B)(iv))(prisoner data);
 - 39.8.1.4 Section 205(r)(3) of the Act (42, U.S.C. § 405(r)(3)) and Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. 108-458, 7213(a)(2) (death data);
 - 39.8.1.5 Sections 402, 412, 421, and 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193) (8 U.S.C. §§ 1612, 1622, 1631, and 1645) (August 22, 1996 (quarters of coverage data);
 - 39.8.1.6 Children's Health Insurance Program Reauthorization Act of 2009, (Pub. L. 111-3) (February 4, 2009) (citizenship data); and
 - 39.8.1.7 Routine use exception to the Privacy Act, 5 U.S.C. § 552a(b)(3)(data necessary to administer other programs compatible with SSA programs).
- E.39.8.2 This Section further carries out Section 1106(a) of the Act (42 U.S.C. § 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. § 3541 et seq.), and related National Institute of Standards and Technology ("NIST") guidelines as outlined in the CMPPA and IEA governing this data, which provide the requirements that the CONTRACTOR must follow with regard to use, treatment, and safeguarding data.
- E.39.9 Definitions
- E.39.9.1 "SSA-supplied data" as used in this Section – Personally Identifiable and Protected Health Information, such as an individual's social security number, income, disability or benefit status or related information, supplied by the Social Security Administration to TennCare in order to determine entitlement or eligibility for federally-funded programs such as Medicaid and CHIP. This information is subject to provisions outlined in a Computer Matching and Privacy Protection Act Agreement (CMPPA) between SSA and the State of Tennessee, and Information Exchange Agreement (IEA) between SSA and TennCare.
 - E.39.9.2 "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 CFR §160.103; OMB Circular M-06-19 located at <http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2006/m06-19.pdf> – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
 - E.39.9.3 "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
 - E.39.9.4 "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or

employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

45. **Attachment I shall be amended by adding a new Service and Definition at the end of the existing Attachment as follows:**

SERVICE	Opioid Use Disorder Treatment
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Definition

Treatments for opioid use disorder are designed and delivered across the continuum of care including but not limited to hospital, residential treatment, Intensive Outpatient Program, Office-Based Opioid Treatment, primary care and peer recovery services. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. The duration of treatment should be based on the needs of the persons served. For opioid use disorder, one essential component within the continuum is Medication Assisted Treatment. Medication Assisted Treatment (MAT) for persons diagnosed with opioid-use disorder is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. The medications used to achieve treatment goals include buprenorphine *and naltrexone* products approved by the Food and Drug Administration (FDA) for the use in the treatment of opioid-use disorder.

All providers treating members with opioid use disorder must either provide Medication Assisted Treatment (MAT) or have a policy for referral to a MAT provider for those members wishing to access MAT.

46. **Attachments III, IV and V shall be deleted and replaced as follows:**

**ATTACHMENT III
GENERAL ACCESS STANDARDS**

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:
 - (a) Transport access Suburban/Rural/Frontier: ≤ 30 miles travel distance and ≤ 45 minutes travel time
 - (b) Transport access Urban: ≤ 20 miles travel distance and ≤ 30 minutes travel time
 - (c) Patient Load: 2,500 or less for physician; one-half of this for a physician extender.
 - (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
 - (e) Documentation/Tracking requirements:
 - + Documentation - Plans must have a system in place to document appointment scheduling times.
 - + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.
- Hospitals
 - (a) Transport access, ≤ 30 miles travel distance and ≤ 45 minutes travel time, except in rural/frontier areas where access distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.
- Long-Term Care Services:

Transport access to licensed Adult Day Care providers, ≤ 20 miles travel distance and ≤ 30 minutes travel time for TennCare enrollees in urban areas, ≤ 30 miles travel distance and ≤ 45 minutes travel time for TennCare enrollees in suburban areas ≤ 60 miles travel distance and ≤ 90 minutes travel time for TennCare enrollees in rural/frontier areas, except where community standards and documentation shall apply.
- General Optometry Services:
 - (a) Transport access ≤ 30 miles travel distance and ≤ 45 minutes travel time, except in rural/frontier areas where community standards and documentation shall apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- All other services not specified here shall meet the usual and customary standards for the community as determined by TENNCARE.

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

ATTACHMENT IV SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

- (1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and
- (2) The following access standards are met:
 - o Transport access \leq 60 miles travel distance and \leq 90 minutes travel time for at least 75% of non-dual members and
 - o Transport access \leq 90 miles travel distance and \leq 120 minutes travel time for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000
Urology	30,000

Access to Opioid Use Disorder (OUD) treatment providers

The CONTRACTOR shall ensure access to OUD treatment providers for the provision of covered services. At a minimum, this means that:

- (1) The CONTRACTOR shall have provider agreements with OUD treatment providers and
- (2) The following access standards are met:
 - o Transport access \leq 45 miles travel distance and \leq 45 minutes travel time for at least 75% of non-dual members and
 - o Transport access \leq 60 miles travel distance and \leq 60 minutes travel time for ALL non-dual members

Availability of OUD Treatment Care

The CONTRACTOR shall provide adequate numbers of OUD treatment providers for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of OUD treatment providers with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
OUD Treatment provider	10,000

(Provider Enrollment File service type coding options for OUD treatment providers are identified in Attachment V.)

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

ATTACHMENT V ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults shall be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all CHILD and ADULT members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Not subject to geographic access standards	Within 30 calendar days
Outpatient Non-MD Services	Transport access ≤ 30 miles travel distance and ≤ 45 minutes travel time for at least 75% of CHILD and ADULT members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for all CHILD and ADULT members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization)	Transport access ≤ 90 miles travel distance and ≤ 90 minutes travel time for 75% of CHILD and ADULT members and ≤ 120 miles travel distance and ≤ 120 minutes travel time for all CHILD and ADULT members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all CHILD and ADULT members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	Not subject to geographic access standards	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Transport access ≤ 30 miles travel distance and ≤ 30 minutes travel time for 75% of CHILD and ADULT members and ≤ 45 miles travel distance and ≤ 45 minutes travel time for all CHILD and ADULT members	Within 10 business days; for detoxification – within 24 hours
Intensive Community Based Treatment Services	Not subject to geographic access standards	Within 7 calendar days
Tennessee Health Link Services	Not subject to geographic access standards	Within 30 Calendar Days

Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, Peer Recovery services or Family Support service)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Intensive Community Based Treatment Services	Adult - 66, or 83 Child – C7, G2, G6, or K1
Tennessee Health Link Services	Adult-31 Child-D7

Amendment 8 (cont.)

Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Recovery Services	88
Family Support Services	49
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult 41
Opioid Use Disorder	P1
Opioid Use Disorder – Enhanced (Reserved for future use)	P2

Amendment 8 (cont.)

47. Attachment VII shall be amended by deleting and replacing Item 16, adding a new Item 17 as follows and renumbering the remaining Items accordingly, including any references thereto.

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
16	Distance/Time from provider to member	Provider Enrollment File	In accordance with this Contract, including Attachments III through V	Time and travel distance as measured by the Suite of GeoAccess software products	Monthly	<p>\$25,000 if ANY of the listed standards are not met, either individually or in combination, on a monthly basis.</p> <p>The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE.</p> <p>TENNCARE may waive the liquidated damage regarding distance to adult day care if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of adult day care providers and the CONTRACTOR has used good faith efforts to develop adult day care providers.</p> <p>LD assessed on a regional basis based on regional reporting.</p>

Amendment 8 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
17	OUO Treatment Network	Provider Enrollment File	October 5, 2018 – OUO access standards to be 50% met. November 5, 2018 - OUO access standards to be 75% met. December 5, 2018 - OUO access standards to be 90% met. January 5, 2019 – OUO access standards to be 100% met	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR’s OUO network as a contract provider	Monthly	<p>\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis.</p> <p>The liquidated damage may be waived if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of MAT providers in the area.</p> <p>The liquidated damage may be lowered to \$5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE LD assessed on a regional basis based on regional reporting</p>

48. Attachment VIII shall be amended by deleting and replacing Item 114, adding a new Item 162, deleting Item 168, amending Items 169 through 177, and adding a new 178 as follows. The remaining Items shall be renumbered accordingly.

114. Tennessee Health Link Semi-Annual Report (A.2.30.4.5)

162. PCMH Membership Reports (see Section A.2.30.10.9)

169. Report on Performance Improvement Projects (see Section A.2.30.12.1)

170. NCQA Accreditation Report (see Section A.2.30.12.2)

171. NCQA revaluation of accreditation status based on HEDIS scores (see Section A.2.30.12.3)

172. Medicaid HEDIS measures marked as “Not Reported” (see Section A.2.30.12.4)

173. Reports of Audited HEDIS Results (see Section A.2.30.12.5)

Amendment 8 (cont.)

- 174. Reports of Audited CAHPS Results (see Section A.2.30.12.6)
- 175. CHOICES HCBS Critical Incidents Report (see Section A.2.30.12.7)
- 176. ECF CHOICES HCBS Reportable Event Report (see Section A.2.30.12.8)
- 177. Behavioral Health Adverse Occurrences Report (see Section A.2.30.12.9)
- 178. Settings Compliance Committee Report (see Section A.2.30.12.10)

49. Attachment XII shall be amended by adding the following Exhibits:

ATTACHMENT XII

**EXHIBIT C.4
RISK ADJUSTED CAPITATION RATES
AmeriGroup – Middle Region
EFFECTIVE 1/1/2017**

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	\$625.27
	Age 1 - 13	\$115.34
	Age 14 - 20 Female	\$198.98
	Age 14 - 20 Male	\$130.22
	Age 21 - 44 Female	\$303.06
	Age 21 - 44 Male	\$196.33
	Age 45 – 64	\$326.48
	Age 65 +	\$571.16
Uninsured/Uninsurable	Age 1 - 13	\$141.81
	Age 14 - 19 Female	\$239.20
	Age 14 – 19 Male	\$161.54
Disabled	Age < 21	\$1,235.67
	Age 21 +	\$850.07
Duals/Waiver Duals	All Ages	\$186.35
Choices Rates	Choices 1 Duals	\$4,626.69
	Choices 2 Duals	\$4,626.69
	Choices 3 Duals	\$1,735.60
	Choices 1 Non-Duals	\$6,095.72
	Choices 2 Non-Duals	\$6,095.72
	Choices 3 Non-Duals	\$3,750.81

ATTACHMENT XII

**EXHIBIT C.5
RISK ADJUSTED CAPITATION RATES
AmeriGroup – East Region
EFFECTIVE 1/1/2017**

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	\$906.12
	Age 1 – 13	\$115.78
	Age 14 - 20 Female	\$194.63
	Age 14 - 20 Male	\$125.26
	Age 21 - 44 Female	\$286.02
	Age 21 - 44 Male	\$185.28
	Age 45 – 64	\$301.38
	Age 65 +	\$463.57
Uninsured/Uninsurable	Age 1 - 13	\$138.41
	Age 14 - 19 Female	\$200.78
	Age 14 – 19 Male	\$137.96
Disabled	Age < 21	\$1,191.40
	Age 21 +	\$728.12
Duals/Waiver Duals	All Ages	\$122.44
Choices Rates	Choices 1 Duals	\$4,898.96
	Choices 2 Duals	\$4,898.96
	Choices 3 Duals	\$1,564.75
	Choices 1 Non-Duals	\$6,586.32
	Choices 2 Non-Duals	\$6,586.32
	Choices 3 Non-Duals	\$3,522.34

ATTACHMENT XII

EXHIBIT C.6
RISK ADJUSTED CAPITATION RATES
AmeriGroup – West Region
EFFECTIVE 1/1/2017

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	\$647.40
	Age 1 – 13	\$96.14
	Age 14 - 20 Female	\$171.01
	Age 14 - 20 Male	\$118.71
	Age 21 - 44 Female	\$252.69
	Age 21 - 44 Male	\$158.83
	Age 45 – 64	\$271.72
	Age 65 +	\$667.66
Uninsured/Uninsurable	Age 1 – 13	\$125.31
	Age 14 - 19 Female	\$167.18
	Age 14 – 19 Male	\$98.03
Disabled	Age < 21	\$1,188.16
	Age 21 +	\$801.25
Duals/Waiver Duals	All Ages	\$161.39
Choices Rates	Choices 1 Duals	\$5,022.90
	Choices 2 Duals	\$5,022.90
	Choices 3 Duals	\$1,831.80
	Choices 1 Non-Duals	\$6,842.03
	Choices 2 Non-Duals	\$6,842.03
	Choices 3 Non-Duals	\$4,336.01

**EXHIBIT D.1
RISK CAPITATION RATES
AmeriGroup – Middle Region
EFFECTIVE 1/1/2018**

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	\$655.26
	Age 1 - 13	\$126.10
	Age 14 - 20 Female	\$218.99
	Age 14 - 20 Male	\$134.38
	Age 21 - 44 Female	\$321.58
	Age 21 - 44 Male	\$210.44
	Age 45 – 64	\$356.53
	Age 65 +	\$610.99
Uninsured/Uninsurable	Age 1 - 13	\$143.62
	Age 14 - 19 Female	\$242.48
	Age 14 – 19 Male	\$152.83
Disabled	Age < 21	\$1,597.07
	Age 21 +	\$969.55
Duals/Waiver Duals	All Ages	\$182.96
Choices Rates	Choices 1 Duals	\$4,918.31
	Choices 2 Duals	\$4,918.31
	Choices 3 Duals	\$1,799.12
	Choices 1 Non-Duals	\$6,489.11
	Choices 2 Non-Duals	\$6,489.11
	Choices 3 Non-Duals	\$4,048.54

ATTACHMENT XII

**EXHIBIT D.2
RISK CAPITATION RATES
AmeriGroup – East Region
EFFECTIVE 1/1/2018**

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	\$813.25
	Age 1 – 13	\$129.44
	Age 14 - 20 Female	\$221.62
	Age 14 - 20 Male	\$143.41
	Age 21 - 44 Female	\$306.44
	Age 21 - 44 Male	\$200.05
	Age 45 – 64	\$338.66
	Age 65 +	\$671.06
Uninsured/Uninsurable	Age 1 - 13	\$174.75
	Age 14 - 19 Female	\$234.40
	Age 14 – 19 Male	\$155.17
Disabled	Age < 21	\$1,498.72
	Age 21 +	\$807.69
Duals/Waiver Duals	All Ages	\$124.97
Choices Rates	Choices 1 Duals	\$4,834.64
	Choices 2 Duals	\$4,834.64
	Choices 3 Duals	\$1,612.98
	Choices 1 Non-Duals	\$6,333.67
	Choices 2 Non-Duals	\$6,333.67
	Choices 3 Non-Duals	\$3,819.19

ATTACHMENT XII

**EXHIBIT D.3
RISK CAPITATION RATES
AmeriGroup – West Region
EFFECTIVE 1/1/2018**

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	\$624.14
	Age 1 – 13	\$103.87
	Age 14 - 20 Female	\$187.62
	Age 14 - 20 Male	\$125.46
	Age 21 - 44 Female	\$268.81
	Age 21 - 44 Male	\$178.55
	Age 45 – 64	\$304.13
	Age 65 +	\$457.70
Uninsured/Uninsurable	Age 1 – 13	\$136.13
	Age 14 - 19 Female	\$236.89
	Age 14 – 19 Male	\$157.80
Disabled	Age < 21	\$1,384.21
	Age 21 +	\$861.54
Duals/Waiver Duals	All Ages	\$164.11
Choices Rates	Choices 1 Duals	\$4,956.35
	Choices 2 Duals	\$4,956.35
	Choices 3 Duals	\$1,912.23
	Choices 1 Non-Duals	\$6,614.64
	Choices 2 Non-Duals	\$6,614.64
	Choices 3 Non-Duals	\$3,842.64

Amendment 8 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2018.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

AMERIGROUP, TENNESSEE, INC.

BY: _____
Larry B. Martin
Commissioner

BY: _____
Edna Willingham
President

DATE: _____

DATE: _____

Supplemental Documentation Required for
Fiscal Review Committee

*Contact Name:	Alma Chilton	*Contact Phone:	615-507-6384		
*Presenter's name(s):	William Aaron				
Edison Contract Number: <i>(if applicable)</i>	#40180	RFS Number: <i>(if applicable)</i>	31865-00372		
*Original or Proposed Contract Begin Date:	January 1, 2014	*Current or Proposed End Date:	December 31, 2018		
Current Request Amendment Number: <i>(if applicable)</i>	8				
Proposed Amendment Effective Date: <i>(if applicable)</i>	July 1, 2018				
*Department Submitting:	Department of Finance and Administration				
*Division:	Division of TennCare				
*Date Submitted:	April 26, 2018				
*Submitted Within Sixty (60) days:	Yes				
<i>If not, explain:</i>	N/A				
*Contract Vendor Name:	AMERIGROUP Tennessee, Inc.				
*Current or Proposed Maximum Liability:	\$7,815,423,650.00				
*Estimated Total Spend for Commodities:	N/A				
*Current or Proposed Contract Allocation by Fiscal Year: (as Shown on Most Current Fully Executed Contract Summary Sheet)					
FY: 2014	FY: 2015	FY: 2016	FY: 2017	FY: 2018	FY: 2019
0.00	\$927,757,750.00	\$1,887,665,900	\$2,000,000,000.00	\$2,000,000,000.00	\$1,000,000,000.00
*Current Total Expenditures by Fiscal Year of Contract: (attach backup documentation from Edison) Attached					
FY: 2014	FY: 2015	FY: 2016	FY: 2017	FY: 2018	FY: 2019
0.00	\$654,157,439.34	\$1,719,763,765.88	\$1,759,964,650.17	\$1,415,428,963.75 (thru 3/28/18)	
IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:			N/A		
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:			N/A		
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding			N/A		

Supplemental Documentation Required for
Fiscal Review Committee

was acquired to pay the overage:			
*Contract Funding Source/Amount:			
State:	\$2,717,869,820.00	Federal:	\$5,097,553,830.00
<i>Interdepartmental:</i>		<i>Other:</i>	
If “ <i>other</i> ” please define:			
If “ <i>interdepartmental</i> ” please define:			
Dates of All Previous Amendments or Revisions: <i>(if applicable)</i>	Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i>		
Amendment #1 - December, 2014	Language modifications		
Amendment #2 – July, 2015	Language modifications		
Amendment #3 – January, 2016	Language modifications and program updates		
Amendment #4 – July 1, 2016	Language modifications		
Amendment #5 – January 2017	Language modifications and program updates; term extension and funding		
Amendment #6- July 1, 2017	Language modifications and program updates; term extension and funding		
Amendment #7 – January 1, 2018	Language modifications and program updates		
Method of Original Award: <i>(if applicable)</i>	RFP		
*What were the projected costs of the service for the entire term of the contract prior to contract award? How was this cost determined?	\$3,775,331,800.00 Cost Proposal		
*List number of other potential vendors who could provide this good or service; efforts to identify other competitive procurement alternatives; and the reason(s) a sole-source contract is in the best interest of the State.	An RFP was released and there were seven (7) proposals submitted. This contract is one of three (3) competitively procured contracts awarded to provide behavioral and medical services to TennCare enrollees statewide.		
Provide information on the circumstances and status of any disciplinary action taken or pending against the vendor during the past 5 years with state agencies/ departments, professional organizations, or through any legal action.	No disciplinary actions identified.		
In addition, please provide any information regarding the due diligence that the Department has taken to ensure that the vendor is not or has not been involved in any circumstances related to illegal activity, including but not limited to fraud.	TennCare googled this contractor and did not identify any illegal activity. Language in the contract requires immediate notification to the state regarding illegal activity or fraud if discovered during the Contract term.		

Supplemental Documentation Required for
Fiscal Review Committee

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CONTRACT AMENDMENT COVER SHEET

Agency Tracking # 31865-00372	Edison ID 40180	Contract #	Amendment # 07
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Contractor Legal Entity Name AMERIGROUP Tennessee, Inc.	Edison Vendor ID 0000011035
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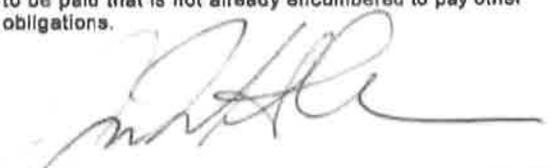
Amendment Purpose & Effect(s)
Updates Scope - Statewide TennCare Managed Care

Amendment Changes Contract End Date: YES NO **End Date:** December 31, 2018

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): \$ 0.00

Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2014	\$0.00	\$0.00			\$0.00
2015	\$324,807,988.00	\$802,949,762.00			\$927,757,750.00
2016	\$660,871,832.00	\$1,226,794,068.00			\$1,887,665,900.00
2017	\$700,340,000.00	\$1,299,660,000.00			\$2,000,000,000.00
2018	\$687,900,000.00	\$1,312,100,000.00			\$2,000,000,000.00
2019	\$343,950,000.00	\$656,050,000.00			\$1,000,000,000.00
TOTAL:	\$2,717,869,820.00	\$5,097,553,830.00			\$7,815,423,650.00

American Recovery and Reinvestment Act (ARRA) Funding: YES NO

<p>Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.</p> 	<p>CPO USE</p>
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Speed Chart (optional)	Account Code (optional)
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AMERIGROUP Tennessee, Inc.
Edison Contract ID: 40180

CONTRACT EXPENDITURES BY FISCAL YEAR
(Payment Detail Attached)

FY 2015	\$654,157,439.34	
FY 2016	\$1,719,763,765.88	
FY 2017	\$1,759,964,650.17	
FY 2018	<u>\$1,415,428,963.75</u>	(Expenditures through March 28, 2018)
TOTAL	<u><u>\$5,549,314,819.14</u></u>	

AMERIGROUP Tennessee, Inc.

Edison Contract ID: 40180

FY 2015

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01067202	0000011035	\$61,663,042.83	2/6/2015
31865	01067203	0000011035	\$36,367,920.53	2/6/2015
31865	01067204	0000011035	\$32,314,102.55	2/6/2015
31865	01084428	0000011035	\$60,717,804.02	3/6/2015
31865	01084429	0000011035	\$34,263,697.01	3/6/2015
31865	01084430	0000011035	\$30,557,637.37	3/6/2015
			\$255,884,204.31	



31865	01100224	0000011035	\$56,410,657.17	4/3/2015
31865	01100225	0000011035	\$40,602,133.57	4/3/2015
31865	01100226	0000011035	\$36,863,173.32	4/3/2015
31865	01104249	0000011035	\$109,541.00	4/10/2015
31865	01115522	0000011035	\$49,692,874.12	5/1/2015
31865	01115523	0000011035	\$40,123,732.90	5/1/2015
31865	01115524	0000011035	\$35,932,388.19	5/1/2015
31865	01134703	0000011035	\$57,692,440.11	6/5/2015
31865	01134704	0000011035	\$42,872,823.90	6/5/2015
31865	01134705	0000011035	\$37,973,470.75	6/5/2015
			\$398,273,235.03	



FY 2015 TOTAL

\$654,157,439.34



AMERIGROUP Tennessee, Inc. - Edison #40180

FY 2016

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01149293	0000011035	\$57,480,921.70	7/7/2015
31865	01149294	0000011035	\$42,155,784.48	7/7/2015
31865	01149295	0000011035	\$38,003,463.57	7/7/2015
31865	01169753	0000011035	\$57,504,000.86	8/7/2015
31865	01169754	0000011035	\$44,141,104.00	8/7/2015
31865	01169755	0000011035	\$39,722,330.20	8/7/2015
31865	01185484	0000011035	\$57,475,512.08	9/4/2015
31865	01185485	0000011035	\$43,935,938.56	9/4/2015
31865	01185486	0000011035	\$41,148,091.70	9/4/2015
			\$421,567,147.15	

31865	01200516	0000011035	\$57,305,773.29	10/2/2015
31865	01200517	0000011035	\$44,153,229.00	10/2/2015
31865	01200518	0000011035	\$40,966,392.92	10/2/2015
31865	01219354	0000011035	\$23,732,745.97	11/6/2015
31865	01219355	0000011035	\$39,083,443.90	11/6/2015
31865	01219356	0000011035	\$28,630,637.95	11/6/2015
31865	01233031	0000011035	\$53,143,146.26	12/4/2015
31865	01233032	0000011035	\$45,352,984.51	12/4/2015
31865	01233033	0000011035	\$40,851,799.62	12/4/2015
31865	01236946	0000011035	\$22,785,457.00	12/11/2015
31865	01246609	0000011035	\$55,927,646.44	12/30/2015
31865	01246610	0000011035	\$46,979,246.54	12/30/2015
31865	01246611	0000011035	\$41,500,140.55	12/30/2015
			\$540,412,643.95	

31865	01250162	0000011035	\$146,393.76	1/8/2016
31865	01265344	0000011035	\$56,284,140.58	2/5/2016
31865	01265345	0000011035	\$48,448,472.46	2/5/2016
31865	01265346	0000011035	\$42,180,522.80	2/5/2016
31865	01282838	0000011035	\$57,066,011.66	3/4/2016
31865	01282839	0000011035	\$50,785,811.58	3/4/2016
31865	01282840	0000011035	\$43,079,826.02	3/4/2016
			\$297,991,178.86	

AMERIGROUP FY 2016 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01299623	0000011035	\$57,557,954.04	4/1/2016
31865	01299624	0000011035	\$52,169,946.14	4/1/2016
31865	01299625	0000011035	\$43,201,573.64	4/1/2016
31865	01319387	0000011035	\$58,239,887.45	5/6/2016
31865	01319388	0000011035	\$53,079,943.48	5/6/2016
31865	01319389	0000011035	\$43,613,249.58	5/6/2016
31865	01335610	0000011035	\$56,153,867.57	6/7/2016
31865	01335611	0000011035	\$52,906,402.82	6/7/2016
31865	01335612	0000011035	\$42,869,971.20	6/7/2016
			\$459,792,795.92	

FY 2016 TOTAL

\$1,719,763,765.88

AMERIGROUP Tennessee, Inc. - Edison #40180

FY 2017

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01355104	0000011035	\$58,611,982.02	7/7/2016
31865	01355105	0000011035	\$54,310,790.12	7/7/2016
31865	01355106	0000011035	\$43,829,276.96	7/7/2016
31865	01369953	0000011035	\$56,988,266.33	8/5/2016
31865	01369954	0000011035	\$53,807,308.59	8/5/2016
31865	01369955	0000011035	\$43,186,711.75	8/5/2016
31865	01385624	0000011035	\$57,402,239.64	9/2/2016
31865	01385625	0000011035	\$53,441,391.91	9/2/2016
31865	01385626	0000011035	\$43,921,958.71	9/2/2016
31865	01400986	0000011035	\$940,904.29	9/30/2016
31865	01400987	0000011035	\$1,334,309.11	9/30/2016
31865	01400988	0000011035	\$1,096,633.16	9/30/2016
			\$468,871,772.59	

31865	01404488	0000011035	\$55,859,657.52	10/3/2016
31865	01404489	0000011035	\$50,719,934.66	10/3/2016
31865	01404490	0000011035	\$42,006,550.73	10/3/2016
31865	01408687	0000011035	\$550,000.00	10/14/2016
31865	01415984	0000011035	\$60,567.57	10/28/2016
31865	01419849	0000011035	\$57,924,261.02	11/4/2016
31865	01419850	0000011035	\$51,669,292.84	11/4/2016
31865	01419851	0000011035	\$42,442,997.09	11/4/2016
31865	01433397	0000011035	\$57,956,914.90	12/2/2016
31865	01433398	0000011035	\$51,060,476.59	12/2/2016
31865	01433399	0000011035	\$42,043,021.35	12/2/2016
31865	01441186	0000011035	\$9,737,964.90	12/16/2016
31865	01441187	0000011035	\$14,532,907.78	12/16/2016
31865	01441188	0000011035	\$10,986,060.32	12/16/2016
31865	01448061	0000011035	\$430,000.00	12/27/2016
31865	01448064	0000011035	\$430,414.76	12/27/2016
31865	01448067	0000011035	\$430,000.00	12/27/2016
31865	01448068	0000011035	\$433,279.60	12/27/2016
31865	01448069	0000011035	\$432,012.02	12/27/2016
			\$489,706,313.65	

AMERIGROUP FY 2017 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01451693	0000011035	\$55,842,164.62	1/6/2017
31865	01451694	0000011035	\$49,602,054.67	1/6/2017
31865	01451695	0000011035	\$40,402,976.28	1/6/2017
31865	01466551	0000011035	\$53,225,044.00	2/3/2017
31865	01466552	0000011035	\$50,608,783.31	2/3/2017
31865	01466553	0000011035	\$42,741,450.43	2/3/2017
31865	01470752	0000011035	\$572,773.19	2/13/2017
31865	01484001	0000011035	\$20,069,026.02	3/2/2017
31865	01484002	0000011035	\$40,283,987.22	3/2/2017
31865	01484003	0000011035	\$34,583,015.18	3/2/2017
31865	01500308	0000011035	\$490,311.69	3/27/2017
			\$388,421,586.61	

31865	01505022	0000011035	\$51,782,846.06	4/7/2017
31865	01505023	0000011035	\$48,393,703.92	4/7/2017
31865	01505024	0000011035	\$40,312,949.68	4/7/2017
31865	01520706	0000011035	\$51,561,793.74	5/5/2017
31865	01520707	0000011035	\$47,625,672.12	5/5/2017
31865	01520708	0000011035	\$39,850,737.68	5/5/2017
31865	01536231	0000011035	\$52,276,747.10	6/2/2017
31865	01536232	0000011035	\$45,010,226.12	6/2/2017
31865	01536233	0000011035	\$35,624,891.20	6/2/2017
31865	01539575	0000011035	\$525,409.70	6/9/2017
			\$412,964,977.32	

FY 2017 TOTAL

\$1,759,964,650.17

AMERIGROUP Tennessee, Inc. - Edison #40180

FY 2018

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01554931	0000011035	\$48,644,766.00	7/7/2017
31865	01554932	0000011035	\$41,723,938.23	7/7/2017
31865	01554933	0000011035	\$34,264,769.48	7/7/2017
31865	01569582	0000011035	\$52,845,739.73	8/4/2017
31865	01569583	0000011035	\$45,761,805.89	8/4/2017
31865	01569584	0000011035	\$37,204,619.58	8/4/2017
31865	01576478	0000011035	\$567,158.70	8/16/2017
31865	01576480	0000011035	\$565,122.47	8/16/2017
31865	01576525	0000011035	\$646,635.49	8/18/2017
31865	01576527	0000011035	\$695,021.54	8/18/2017
31865	01584404	0000011035	\$53,339,619.42	9/1/2017
31865	01584405	0000011035	\$45,933,061.82	9/1/2017
31865	01584406	0000011035	\$38,140,655.45	9/1/2017
31865	01591440	0000011035	\$923,685.79	9/15/2017
31865	01594455	0000011035	\$701,592.55	9/18/2017
31865	01594963	0000011035	\$9,501.00	9/22/2017
			\$401,967,693.14	

31865	01601746	0000011035	\$1,520,830.67	10/4/2017
31865	01601747	0000011035	\$2,185,142.26	10/4/2017
31865	01601749	0000011035	\$1,010,308.21	10/4/2017
31865	01602129	0000011035	\$45,676,748.92	10/6/2017
31865	01602128	0000011035	\$53,646,430.02	10/6/2017
31865	01602130	0000011035	\$37,651,919.21	10/6/2017
31865	01605150	0000011035	\$1,808,423.97	10/11/2017
31865	01605151	0000011035	\$2,216,890.90	10/11/2017
31865	01605152	0000011035	\$1,311,530.01	10/11/2017
31865	01608746	0000011035	\$1,430,401.22	10/18/2017
31865	01608749	0000011035	\$2,001,646.64	10/18/2017
31865	01608751	0000011035	\$1,141,911.48	10/18/2017
31865	01608787	0000011035	\$700,067.51	10/19/2017
31865	01612093	0000011035	\$1,362,742.08	10/25/2017
31865	01612096	0000011035	\$1,914,874.48	10/25/2017
31865	01612098	0000011035	\$1,021,716.10	10/25/2017
31865	01615896	0000011035	\$1,514,471.26	11/1/2017
31865	01615898	0000011035	\$1,853,679.86	11/1/2017
31865	01615899	0000011035	\$1,029,095.01	11/1/2017
31865	01616350	0000011035	\$45,683,546.49	11/3/2017
31865	01616349	0000011035	\$53,941,633.23	11/3/2017
31865	01616351	0000011035	\$37,496,343.38	11/3/2017

AMERIGROUP FY 2018 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01619405	0000011035	\$1,455,604.17	11/8/2017
31865	01619413	0000011035	\$2,096,355.13	11/8/2017
31865	01619421	0000011035	\$1,346,252.20	11/8/2017
31865	01623181	0000011035	\$1,728,125.66	11/15/2017
31865	01623183	0000011035	\$2,145,647.04	11/15/2017
31865	01623187	0000011035	\$1,227,454.17	11/15/2017
31865	01626809	0000011035	\$1,618,735.78	11/22/2017
31865	01626813	0000011035	\$2,015,596.45	11/22/2017
31865	01626814	0000011035	\$1,141,498.28	11/22/2017
31865	01629697	0000011035	\$901,053.34	11/30/2017
31865	01629704	0000011035	\$1,391,490.25	11/30/2017
31865	01629705	0000011035	\$2,043,183.67	11/30/2017
31865	01629707	0000011035	\$1,131,207.13	11/30/2017
31865	01630146	0000011035	\$45,770,987.41	12/1/2017
31865	01630145	0000011035	\$54,469,150.67	12/1/2017
31865	01630147	0000011035	\$38,287,172.01	12/1/2017
31865	01633650	0000011035	\$1,200,228.18	12/6/2017
31865	01633653	0000011035	\$1,745,815.22	12/6/2017
31865	01633655	0000011035	\$943,416.27	12/6/2017
31865	01637265	0000011035	\$891,209.32	12/14/2017
31865	01637248	0000011035	\$1,681,876.85	12/13/2017
31865	01637250	0000011035	\$2,387,726.88	12/13/2017
31865	01637251	0000011035	\$1,383,306.67	12/13/2017
31865	01640419	0000011035	\$1,546,911.37	12/20/2017
31865	01640421	0000011035	\$2,006,072.45	12/20/2017
31865	01640422	0000011035	\$1,213,214.23	12/20/2017
31865	01644106	0000011035	\$1,628,806.73	12/29/2017
31865	01644107	0000011035	\$2,175,325.99	12/29/2017
31865	01644108	0000011035	\$1,181,987.86	12/29/2017
			\$476,875,764.29	

31865	01647656	0000011035	\$54,159,188.58	1/5/2018
31865	01647657	0000011035	\$45,076,133.71	1/5/2018
31865	01647658	0000011035	\$37,640,818.67	1/5/2018
31865	01647296	0000011035	\$2,335,182.32	1/5/2018
31865	01647297	0000011035	\$3,161,191.52	1/5/2018
31865	01647298	0000011035	\$1,806,377.00	1/5/2018
31865	01650955	0000011035	\$1,474,483.23	1/10/2018
31865	01650956	0000011035	\$2,170,660.43	1/10/2018
31865	01650961	0000011035	\$1,236,384.54	1/10/2018
31865	01654237	0000011035	\$1,667,043.29	1/18/2018

AMERIGROUP FY 2018 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01654239	0000011035	\$2,238,534.80	1/18/2018
31865	01654241	0000011035	\$1,264,471.89	1/18/2018
31865	01657557	0000011035	\$1,465,659.76	1/24/2018
31865	01657559	0000011035	\$1,824,449.19	1/24/2018
31865	01657560	0000011035	\$850,250.75	1/24/2018
31865	01661085	0000011035	\$2,932,125.99	1/31/2018
31865	01661086	0000011035	\$3,896,740.98	1/31/2018
31865	01661088	0000011035	\$2,194,005.94	1/31/2018
31865	01661134	0000011035	\$898,373.04	2/1/2018
31865	01661579	0000011035	\$40,799,777.16	2/2/2018
31865	01661580	0000011035	\$32,996,941.71	2/2/2018
31865	01661581	0000011035	\$32,114,977.96	2/2/2018
31865	01665433	0000011035	\$1,661,013.90	2/7/2018
31865	01665434	0000011035	\$1,980,654.75	2/7/2018
31865	01665436	0000011035	\$1,308,903.65	2/7/2018
31865	01665484	0000011035	\$2,960,303.30	2/8/2018
31865	01665485	0000011035	\$2,451,165.54	2/8/2018
31865	01665486	0000011035	\$1,324,553.80	2/8/2018
31865	01669222	0000011035	\$1,950,306.76	2/14/2018
31865	01669223	0000011035	\$2,835,622.24	2/14/2018
31865	01669224	0000011035	\$1,468,060.37	2/14/2018
31865	01669263	0000011035	\$957,222.27	2/15/2018
31865	01673275	0000011035	\$1,625,278.14	2/22/2018
31865	01673277	0000011035	\$2,143,661.30	2/22/2018
31865	01673279	0000011035	\$1,217,924.43	2/22/2018
31865	01677254	0000011035	\$1,496,616.53	2/28/2018
31865	01677255	0000011035	\$2,130,251.79	2/28/2018
31865	01677256	0000011035	\$1,238,139.14	2/28/2018
31865	01677767	0000011035	\$89,543,116.87	3/2/2018
31865	01677768	0000011035	\$65,772,926.78	3/2/2018
31865	01677769	0000011035	\$57,721,390.28	3/2/2018
31865	01681334	0000011035	\$1,408,870.34	3/7/2018
31865	01681335	0000011035	\$1,915,307.81	3/7/2018
31865	01681337	0000011035	\$1,264,729.96	3/7/2018
31865	01681368	0000011035	\$1,046,207.41	3/9/2018
31865	01684548	0000011035	\$1,670,660.39	3/14/2018
31865	01684549	0000011035	\$2,586,412.21	3/14/2018
31865	01684550	0000011035	\$1,391,198.22	3/14/2018
31865	01688686	0000011035	\$1,480,232.67	3/21/2018
31865	01688687	0000011035	\$2,097,223.17	3/21/2018
31865	01688688	0000011035	\$1,172,342.26	3/21/2018
31865	01692615	0000011035	\$1,437,417.49	3/28/2018
31865	01692616	0000011035	\$1,998,253.77	3/28/2018

AMERIGROUP FY 2018 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
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31865	01692617	0000011035	\$1,125,766.32	3/28/2018
			\$536,585,506.32	

FY 2018 TOTAL **\$1,415,428,963.75**
